S. HRG. 101-58

NOMINATION

HEARING

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

ON

ADDITIONAL CONSIDERATION OF DR. LOUIS W. SULLIVAN, OF GEORGIA, TO BE SECRETARY OF HEALTH AND HUMAN SERVICES

FEBRUARY 27, 1989

1043-A;
1043-B

Printed for the use of the Committee on Labor and Human Resources

U.S. GOVERNMENT PRINTING OFFICE

97-968 WASHINGTON : 1989

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

S541-28

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NOMINATION

MONDAY, FEBRUARY 27, 1989

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, in room SD-430, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the committee) presiding.

Present: Senators Kennedy, Harkin, Hatch and Durenberger.

OPENING STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. We will come to order.

It is an honor to welcome Dr. Louis Sullivan to the Senate Labor and Human Resources Committee. Our committee shares jurisdiction with the Finance Committee on the programs in the Department of Health and Human Services, and we look forward to hearing Dr. Sullivan's views on issues of vital importance to the health and welfare of the American people.

The problems the Secretary of HHS will confront over the next four years go to the very heart of the many different challenges facing the Nation.

Thirty-seven million citizens have no health insurance coverage, either public or private. As a result, they are denied access to essential health care that should be a fundamental human right.

Thirty million senior citizens and their families are at risk for the devastating cost of long-term care, either in a nursing home or in their own homes.

The AIDS epidemic continues to threaten our society with the most devastating plague of the 20th century. Forty-nine thousand Americans have already died from this disease; over 1.5 million are infected with the deadly virus, and their needs could well bankrupt our health care system in the decade ahead.

The National Institutes of Health are the envy of the world for their record of achievement in biomedical research but the United States is behind 18 other countries in protecting children against infant mortality.

Minority citizens die at rates that shame us all; unnecessary deaths among blacks and other minorities from preventable and treatable illnesses number almost 60,000 a year.

Hospitals are reeling under the hurdles of soaring costs. An economical and effective prospective payment system is an essential element in the struggle against excessive inflation in these costs, but health care must never be held hostage to attempts to balance the budget on the backs of our hospitals.

I commend President Bush for nominating Dr. Sullivan to lead us in meeting these and other challenges. He is a distinguished physician, medical researcher and medical administrator. I am also pleased to note that he has served or studied at a number of Massachusetts institutions, including Boston University, Harvard Medical School, Boston City Hospital, and the Boston Sickle Cell Center.

One of the most impressive achievements in his distinguished career is the creation of the Morehouse School of Medicine. As the school's first Dean and President, Dr. Sullivan created the medical school and built it into one of the most respected institutions for the training of physicians.

He is widely recognized by his peers for his leadership, energy, commitment, and contributions to academic medicine.

He is well-qualified for the position of Secretary of HHS, and I am honored to welcome him here this morning.

I note that we have a distinguished Member of Congress present who has been good enough to take some time to come over and share with us some impressions of the nominee, and we welcome Congressman Gingrich.

STATEMENT OF HON. NEWT GINGRICH, A MEMBER OF CONGRESS FROM THE STATE OF GEORGIA

Mr. GINGRICH. Thank you, Mr. Chairman.

I appreciate very much the chance to be here, because in addition to all of the fine work Dr. Sullivan did in your fair city, he also has played a very major role in Atlanta, and as the Congressman who represents the Atlanta airport area, I have known him since he first began working to create Morehouse Medical School, which is the first private, black-oriented medical school founded in over 70 years.

When I first visited him, he had one small office and I think three other people on this staff, and he has created a national class institution.

He is a researcher, a scientist, a medical doctor, and an entrepreneur of the first caliber.

I just wanted to come by for a minute to commend him to the committee from the standpoint that I cannot imagine anyone who has a broader commitment to ensuring that all Americans have access to health care and who has a broader commitment to ensuring that all Americans have access to the values of discipline and hard work and education, which have been his own personal experience and his family's experience.

I have known Dr. Sullivan for over a decade. I watched him work hard in Atlanta; I watched him work very effectively in the halls of Congress and in the Executive Branch. He understands that the "thousand points of light" which is in many ways the Republican effort for volunteerism can occasionally use Government batteries to ensure that the light is fully solid. And he has been good at combining both private and public activities.

Finally, in addition to his personal integrity, the depth of his commitment, he has a very rapid learning curve, and all of you have been able to watch him over the last few months begin to

learn this city and how tough and different this city is than other places he has been.

I am confident that he is going to lead all of us in thinking through some problems, frankly, Senator Kennedy, that I think you have a deep interest in, thinking them through in a way that both meets conservative values and liberal goals, and thinking them through in a way that, on a bipartisan basis, we can be very proud to have worked with him as Secretary of Health and Human Services.

So it is a great pleasure to come here today as a Georgian and simply introduce my fellow Georgia, Dr. Sullivan. And I will get out of your way and let you go on with the business of the Senate.

The CHAIRMAN. Thank you very much, Congressman, for a very flattering and truthful statement. We thank you for coming over.

Senator Hatch?

OPENING STATEMENT OF SENATOR HATCH

Senator HATCH. Mr. Chairman, I am very pleased to join you in welcoming Dr. Sullivan to our committee today.

Dr. Sullivan has my full support as President Bush's nominee as Secretary of the Department of Health and Human Services. I can tell you that it is absolute and unmitigated support. I am very impressed with Dr. Sullivan and the type of a human being that he is.

The Department of Health and Human Services has the third-largest budget in the world. Only the U.S. and Soviet governments have budgets that are larger than HHS administers. Of course, it reviews countless domestic programs in America, which touch every American every day. The thankless task of administering this great agency, of course, as a mammoth agency, has to fall on the shoulders of a compassionate professional. And, I know that Dr. Sullivan is just exactly that type of a person.

First and foremost, Dr. Sullivan is a respected health care professional who has worked on the problems that he will have to address as Secretary of Health and Human Services. He has first-hand knowledge of the health care needs of all Americans. He has worked to help low-income mothers and their children receive needed services while working against poverty in America. He has cared for the elderly and understands their needs. His goals for systematic health care changes will help us as we near the year 2000 on this planet.

It seems to me the most articulate description of Dr. Sullivan's capabilities was penned by Dr. Sullivan himself, when he was asked to describe his qualifications for the job. He said:

> I have long been committed to improving health care to underserved segments of our country. My commitment to improved health and human services for minorities, children and the elderly have caused me to become actively involved at the national, State and local levels to improve the efficiency and quality of care to these groups.

These are indeed the characteristics that I believe we need in the Secretary of Health and Human Services. So I am delighted that Dr. Sullivan—a progressive, compassionate conservative with proven ability as an administrator—will accept the challenge of heading this essential Federal agency.

His responsibilities will be large and diverse, and of course, I personally admire your willingness, Dr. Sullivan, to join the ranks of dedicated public servants who presently serve and who have served in the past and who have served in this particular position.

So I am very proud to be a supporter of yours, and I look forward to completing these hearings and, of course, to your debate on the Floor and your confirmation, which I am sure will occur before the week is out.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Durenberger?

OPENING STATEMENT OF SENATOR DURENBERGER

Senator DURENBERGER. Thank you, Mr. Chairman, Dr. Sullivan.

It is my privilege, Mr. Chairman, to go through this process with Dr. Sullivan twice. The first time was at the Finance Committee last week. For your benefit, Mr. Chairman, and my Ranking Member, after everyone else had asked their questions, I was struck by the characterization that we are facing a sort of "kinder and gentler George and Lou meet the realities of the budget deficit" and "read my lips" at the same time.

It was a very interesting process in the Finance Committee to watch practically every member express concern for the health side of that committee's agenda rather than focusing a lot of attention on other things that they may have spent their time on. Much of which is obviously what the chairman of this committee in his opening statement talked a great deal about.

Mr. Chairman, during the Finance Committee's hearing Dr. Sullivan was also asked by one of our colleagues if you had to name one thing that you would like to be remembered for. And as I listened to your opening statement, I think Dr. Sullivan's response to that question was very similar to a part of your own opening statement, and so I think you are going to find in the President's nominee a person who is as committed as you and the other members of this committee in changing our definition of health in this country in some appropriate ways.

On Saturday, after that experience with the Finance Committee, I spoke to the American Medical Association's House of Delegates—you were not able to accept their invitation, so I sort of covered all of our bases. And one of the observations I found myself making in light of current events, and in light of a statement I was accurately quoted as making in the Washington Post last week about Dr. Sullivan, was that some of us would have preferred somebody who could have "hit the ground running"—and my observation was isn't it sort of funny that the person who is not of Washington breezes through the Finance Committee 19-to-nothing, and over in another committee, the person who supposedly was going to "hit the ground running" in another department is all bogged down.

Today, I feel so much better about the nominee and what he can bring to this agenda, with the help of the people on this committee and in the other committees, and while I have been committed to Dr. Sullivan from the start, I am even more committed today, and I certainly recommend him to all of my colleagues.

The CHAIRMAN. Very fine. At this point we will receive for the record a statement by Senator Simon.

[The prepared statement of Senator Simon follows.]

PAUL SIMON
ILLINOIS

COMMITTEES
LABOR AND HUMAN RESOURCES
JUDICIARY
FOREIGN RELATIONS
BUDGET

United States Senate
WASHINGTON, DC 20510

February 27, 1989

Thank you Mr. Chairman:

I am pleased that the Bush Administration selected Dr. Louis Sullivan for the position of Secretary of Health and Human Services. Dr. Sullivan's credentials are most impressive and I believe he will bring outstanding leadership and direction to the Department of Health and Human Services.

When I met with Dr. Sullivan we discussed some key concerns of mine and I would like to re-iterate those concerns to Dr. Sullivan for inclusion in his priorities for the next year. Of highest priority is the issue of quality health care for the millions of Americans undeserved. Additionally, I am concerned about the following:

the growing infant mortality rate in this country especially in the minority population

long term health care

the number of hospital closings due to continuous cuts in the Medicare budget

the need for increased funding and research in the area of substance abuse and mental illness

AIDS research and treatment since it not only impacts hundreds of thousands of Americans but some one million in Africa

a renewed commitment to our national research agenda by the National Cancer Institute and the Food and Drug Administration

expansion not termination of the Community Services Block Grant program.

Dr. Sullivan, I am pleased that you will assume the leadership of one of the most important and challenging cabinet positions in the Bush Administration. I want you to know you have my support and my vote. I hope that you will come back and meet with this committee throughout your tenure. We look forward to a close working relationship with the Secretary of the Department of Health and Human Services.

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Suite 212
East St Louis, IL 62203
618/398-7707

250 West Cherry
Room 115-B
Carbondale, IL 62901
618/457-3653

The CHAIRMAN. Doctor, we welcome you here to the committee. We notice some members of your family are joining you. Would you like to introduce them to the committee? We would be more than welcome to have them presented.

STATEMENT OF DR. LOUIS W. SULLIVAN, NOMINATED TO BE SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. SULLIVAN. Thank you very much, Mr. Chairman and members of the committee.

Indeed, I would like to introduce my wife, Ginger, of some 35 years; and my daughter, Shanta, a graduate of Dartmouth College. She, along with my two sons, who could not be here, because my older son who is a physician had to be at his clinic in Atlanta, working today, and my younger son, who is a senior at the University of Virginia, where he is president of his class and responsible for a program there. So those are the members of my family, and I am very pleased to have this opportunity to introduce them.

The CHAIRMAN. Please proceed.

Dr. SULLIVAN. Thank you, Mr. Chairman and members of the committee.

It is a pleasure to appear before you today. As a physician and educator, I have long been aware of the work of the Labor and Human Resources Committee. Indeed, much of the work done by this committee has been of special concern to me.

As President of Morehouse School of Medicine, I have offered testimony many times in previous years on various aspects of minority health and minority health manpower.

It is an honor to be the nominee of our President for Secretary of Health and Human Services. I am honored by the trust and confidence of a friend and sobered by the magnitude of the task before me should my nomination be confirmed by the Senate.

For the past two months, I have been acquainting myself with the vast collection of agencies, bureaus, institutes, administrations, programs, hospitals and research facilities that come together under the umbrella of this Department. Each of these many organizations is of vital importance to the health and well-being of our citizens.

It may be easy for some to ask how or how this Department came to be. It may be easy for some to claim no unity, no unifying reason for Health and Human Services. But I see in the faces and hear in the voices of those many employees of Health and Human Services whom I meet; I see and hear the concern of dedicated civil servants, the men and women who have chosen to devote their lives in service to their fellow citizens. I believe this concern and dedication that I see is reflective of the commitment of the more than 114,000 people who are the Department of Health and Human Services. Their commitment to serve is the unifying force at Health and Human Services.

If ever a government has offered a place, a department, an agency where an individual is given the opportunity to "do" for his fellow citizen, it is this department.

President Bush has called for a "kinder and gentler" nation, as previously noted this morning. There are few places in the Federal

Government where that call can produce a greater return than Health and Human Services.

But the service inherent in the name of this department must be more than good will. While much of this committee's work focuses on the scientific and technical, I am aware of your commitment to the human element, that desire to see the advances of science and technology applied to the benefit of the individual. Likewise, the personal concern and dedication that I see at Health and Human Services must continue to be translated into action.

There are some very real areas of concern to the department and to Congress. The ongoing solvency of Social Security must be assured. We must find a way to contain escalating medical costs without sacrificing our goal of quality health care for all. We must continue to find ways to better serve our Nation's poor and help them work their way out of poverty. Ways must be found to strengthen family life in our country and to restore our sense of community, our shared sense of responsibility and commitment to each other.

We must firmly and persistently address the issue of drugs in our society. This is a problem that affects us all. It gnaws at the fiber of our families and the stability of our social structure. If confirmed by the Senate, I will work long and hard with this committee, with the President, and with the President's drug advisor, in doing all that I can to halt this terrible epidemic.

A strong biomedical research effort must continue in our quest to find a cure for AIDS; nor can we forget our continued assault against cancer, heart disease, diabetes, arthritis and the many other disorders afflicting our citizens.

In this regard, President Bush has called for an initiative to expedite new therapies in the treatment of AIDS and other life-threatening diseases. The FDA has already undertaken a number of steps to improve the new drug review process and is currently establishing steps to expedite new therapies for major disorders.

In view of our limited resources, it is important to focus our efforts on the poor, on the disadvantaged and the neglected in our society. We must see that rural and inner city health needs are not forgotten, that the poor of our Nation are cared for properly and with dignity. If confirmed by the Senate, the relatively poor health status of our minority citizens, noted in the Secretary's report in 1985—which includes our black, Hispanic, Native American and those others who have yet to fully realize the American dream—that health status will be of special concern to me.

We have seen some progress in this area. No longer are minority children less likely to have been immunized than others. The Department's Office of Minority Health has been organized and has begun to function during the past two years.

On the other hand, the number of minorities enrolled in health professions schools has increased slightly, if at all, during the past eight years.

The examples I have cited are small steps. There is much yet to be done. And if confirmed by the Senate, I will give increased attention and support to these issues.

These are but a few of the problems we face. These are only a few of the concerns of us all. And if confirmed by the Senate, I look

forward to working with you in addressing these and the many other issues under this committee's jurisdiction.

In that connection, let me make clear once more my views with respect to abortion. I believe abortion is wrong and that it is inconsistent with the best of family values. I oppose abortion except in cases of rape or incest, or when the life of the mother is in danger.

Furthermore, I oppose Federal funding of abortions except to save the life of the mother.

Mr. Chairman, should I be confirmed for this post, we may have differences in approach to various issues from time to time. But I know that we agree on the goals of better medical care, stronger families, and a healthier and more secure future, with equal opportunity for all Americans.

Thank you for this opportunity to present this statement.

[The biographical sketch of Dr. Sullivan follows:]

RESPONSE TO INFORMATION REQUESTED OF DR. LOUIS SULLIVAN

A. BIOGRAPHICAL:

1. Name: Louis Wade Sullivan

2. Address: 1525 New Hope Road
Atlanta, GA 30331

3. Date and place of birth: 11/03/33 - Atlanta

4. Marital Status: Married to Eva M. Williamson (Ginger)

5. Name and ages of children: Paul J. Sullivan - 32
Shanta E. Sullivan - 27
Halsted L. P. Sullivan - 21

6. Education: Morehouse College, B.A., 1954
Boston University, M.D., 1958

7. Employment record:

ACADEMIC AND PROFESSIONAL POSITIONS

Medical Student Fellow of the National Foundation--Summer, 1956
Internship: New York Hospital--Cornell Medical Center, 1958-59
Medical Residency: New York Hospital, Cornell Medical Center, 1959-60
General Pathology Residency: Massachusetts General Hospital, 1960-61
Opportunity Fellow: John Hay Whitney Foundation, 1960-61
Research Fellow in Medicine (Hematology): Thorndike Memorial Laboratory (Harvard Medical Unit), Boston City Hospital and Harvard Medical School, 1961-63
Instructor in Medicine: Harvard Medical School, 1963-64
Research Associate: Thorndike Memorial Laboratory, Boston City Hospital, 1963-64
Assistant Professor of Medicine: New Jersey College of Medicine, 1964-66
U.S. Public Health Service Research Career Development Awardee (NIH), 1965-66, 1967-71
Assistant Attending Physician: Medical Center, Jersey City, NJ, 1964-65
Associate Attending Physician: Medical Center, Jersey City, NJ, 1965-66
Co-Director of Hematology: Boston University Medical Center, 1966-75
Assistant Professor of Medicine: Boston University School of Medicine, 1966-68

Assistant Visiting Physician: University Hospital and the Fifth and Sixth (Boston University) Medical Services, Boston City Hospital, 1966-68
Associate Professor of Medicine: Boston University School of Medicine, 1968-74
Associate Professor of Physiology: Boston University School of Medicine, 1970-74
Associate Visiting Physician: University Hospital and the Fifth and Six (Boston University) Medical Services, Boston City Hospital, 1968-74
Co-Project Director, Boston Sickle Cell Center: Trustees of Health and Hospitals, 1972-73
Project Director, Boston Sickle Cell Center: Trustees of Health and Hospitals, 1973-75
Director of Hematology: Boston City Hospital, 1973-75
Professor of Medicine and Physiology: Boston University School of Medicine, 1974-75
Professor of Nutrition: Boston University School of Dentistry, 1974-75
Visiting Physician: Boston City Hospital, 1974-75
Visiting Physician: University Hospital, 1974-75
Professor of Biology and Medicine: Morehouse College, 1975-81
Professor of Medicine, the Morehouse School of Medicine, 1981 - (on sabbatical leave, beginning at time of Senate confirmation)
Dean and Director, School of Medicine at Morehouse College, 1975-81
President and Dean, The Morehouse School of Medicine, 1981-85
President, The Morehouse School of Medicine, 1985- (will resign at time of Senate confirmation)

8. Government experience:

Special Consultant, General Clinical Research Center Committee, Division of Research Facilities and Resources, National Institutes of Health, 1969-73
Consultant Physician, Veterans Administration Hospital, Boston, 1969-71
Sickle Cell Anemia Advisory Committee, National Institutes of Health, 1971-73
Blood Diseases and Blood Resources Advisory Committee, National Heart and Lung Institute, National Institutes of Health, 1974-75
Member, National Advisory Council, Division of Research Resources, National Institutes of Health, 1977-79
Member, Advisory Committee to the Director, National Institutes of Health, 1980-82
Member, Career Development Committee, Veterans Administration Medical Research Services, 1980-84

Member, Blood Products Advisory Committee, Food and Drug Administration, 1981-85
National Cancer Advisory Board, National Cancer Institute (NIH), 1986-92

9. Memberships:

Medical Advisory Board, National Leukemia Association, 1968-70 (Chairman, 1970)
Associate Editor, Nutrition Reports International, 1969-73
Member of Training Committee, American Society of Hematology, 1969-71
Consultant Physician, Framingham Union Hospital, 1970-75
Chairman of the Board, University Comprehensive Health Program, 1975-77
Editorial Board, Journal of Medical Education, 1977-78
Member, National Board of Medical Examiners, 1977-80
Member, Board of Directors of National Fund for Medical Education, Educational Advisory Committee, 1977-80
Member, Task Force on Minority Opportunities in Medicine, Association of American Medical Colleges, 1976-78
Member, Task Force on the Support of Medical Education, Association of American Medical Colleges, 1977-80
Member, Visiting Committee, Harvard Medical and Dental Schools, 1983-88
Member, Board of Visitors, School of Medicine, University of California at Davis, 1983-
Member, Commission on Health and Human Services, Southern Regional Education Board, 1985-87
Vice Chairman, Commission on Health and Human Services, Southern Region Education Board, 1985-87
Member, Board of Directors, Friends of the National Library of Medicine, 1985-
Member, Advisory Committee to the Harvard MIT Division of Health Science and Technology, 1987-
Member, The Robert Wood Johnson Health Policy Fellowship Board, Institute of Medicine, National Academy of Sciences, 1988-1991
Fellow, American College of Physicians, 1981
Member, Health Care Financing Subcommittee, American College of Physicians, 1988-
Editorial Board of the Journal of the Medical Association of Georgia
Member, Association for Academic Minority Physicians, 1985
President, 1988-89
Member, Board of Directors, Southern Center for International Studies, 1988-

Member, Board of Directors, University Center in Georgia, 1988-89
Member, Board of Directors, Medical Education for South African Blacks, Inc.

MEDICAL SCHOOL TEACHING AND ADMINISTRATIVE ACTIVITIES

Boston University
Coordinator of Hematology Section, Biology of Health, 1971-75
Coordinator of Hematology Section, Biology of Disease, 1964-66
Chairman, Third Year Teaching Committee of the Department of Medicine, 1964-74
Chairman, Third Year Promotions Committee, 1972-74
Member, Curriculum Committee, 1969-74
Chairman, Search Committee for the Chairperson, Department of Obstetrics and Gynecology, 1974

CIVIC ORGANIZATIONS

Atlanta Rotary Club, 1977- (on leave 1/15/89)
Member of Board, Georgia Division, American Cancer Society, 1976-82
Member of Board, Atlanta Division, American Red Cross, 1976-82
Member of Board, Atlanta Division, American Lung Society, 1976-82
Member, National Executive Board, Boy Scouts of American, 1986-
Atlanta Council Representative to the National Council, Boy Scouts of America, 1988-
Member, Board of Trustees, Woodruff Arts Center, Atlanta, 1986-

10. Political affiliations and activities:

Campaign to elect George Bush (1988) - $1,000
No offices held
Services rendered: use of my home for a fundraising event for the George Bush campaign, May 13, 1988

11. Honors and Awards:

State Committee on the Life and Health of Black Georgians: Honoree of the Year for Outstanding Contributors to Education in Georgia, 1983
Southern Christian Leadership Conference, Drum Major Award for Service to Education, 1982

The Sterling Drug Company: Endowed Visiting Professorship in Pharmacology, in the name of Louis W. Sullivan, M.D, 1980
New York Hospital-Cornell Medical Center Affiliated Alumni Association: Outstanding Alumnus Award, May 11, 1984
National Association of Minority Medical Educators: Honoree for outstanding contributions to the education of minorities in medicine, September 22, 1984
Boston University: Alumni Award for Distinguished Public Service, October 19, 1985
The Equitable: Black Achievement Award in Education, 1986
The Atlanta Urban League: Distinguished Community Service Award, November 19, 1987

12. Published writings: See Attached

13. Speeches:

"A Summary of Major Achievements of the Morehouse School of Medicine 1975-1988." Prepared for The House and Senate Appropriations Committees of the Georgia General Assembly. January 17, 1989.

Introduction of Barbara P. Bush to the Republican National Convention, New Orleans, LA. August 18, 1988.

Report of the President of the Morehouse School of Medicine to the House of Delegates, National Medical Association at its Annual Meeting, Los Angeles, CA. July 31, 1988.

Remarks for the Kaiser HPRC (Health Promotion Resource Center) Advisory Committee, Morehouse School of Medicine. July 26, 1988.

Testimony of Louis Sullivan, M.D., President, Morehouse School of Medicine and past President of the Association of Minority Health Professions Schools before the Subcommittee on Labor, Health and Human Services. Education and Related Agencies, Committee on Appropriations concerning Fiscal Year 1989 Funding for Health Professions Training, Minority Biomedical Research and Student and Institutional Aid on May 4, 1988.

"Minorities, Medical Education, and Health Care -- The Crises Worsens," Louis W. Sullivan, M.D., President, Morehouse School of Medicine, Atlanta, Georgia. Presented at the Harlem Hospital Centennial National Health Conference, on April 22, 1988, at the Grand Hyatt Hotel, New York, NY.

"Myth, Reality, and the Future in Southern Africa: Challenges for a New Administration," March 30-31, 1988, the Carter Library, Summary of Discussions.

Closing Remarks: Symposium on Career Opportunities in the Biomedical Sciences, March 18, 1988, Omni Hotel, Atlanta.

Opening Remarks for "Educating Tomorrow's Leaders Today," Louis W. Sullivan, M.D., President, Morehouse School of Medicine, February 19, 1988. A Symposium on Higher Education, part of the inaugural activities for the installation of Dr. LeRoy Keith, Jr., as the eighth President of Morehouse College.

The Morehouse School of Medicine, 1987-88: A Progress Report. Submitted to the Committees on Appropriations of the Georgia General Assembly, Atlanta, Georgia, January 19, 1988, by Louis W. Sullivan, M.D., President.

Impressions and Perspectives of South Africa.

Impressions of South Africa and the MESAB/South Africa Advisory Council. Report on a trip to South Africa, November 20-December 1, 1987.

A Bittersweet Holiday Message in 1987.

Welcoming Remarks, National Black Leadership Initiative on Cancer, Atlanta, GA, November 20, 1987.

Urban League Awards Dinner, November 19, 1987.

National Black Leadership Initiative on Cancer. (Presented to the National Cancer Advisory Board on September 28, 1987). Louis W. Sullivan, M.D. - Member, NCAB.

Report of the President of the Morehouse School of Medicine to the House of Delegates, National Medical Association, at its Annual Meeting, New Orleans, LA, August 2, 1987.

The Morehouse School of Medicine: A Report on its First Decade, and the Plans for its Second Ten Years, Louis W. Sullivan, M.D., President.

Remarks of Louis W. Sullivan, M.D., President, Morehouse School of Medicine, to the Atlanta (Peachtree) Kiwanis Club, March 11, 1986.

The Morehouse School of Medicine, 1985-1986, A Progress Report. Submitted to the Joint Committees on Appropriations of the Georgia General Assembly, Atlanta, GA, January 24, 1986, by Louis W. Sullivan, M.D., President.

Statement of Louis W. Sullivan, M.D., President and Dean, Morehouse School of Medicine, October 23, 1985, 2:00 p.m. (Cork Institute establishment.)

The Morehouse School of Medicine: Past, Present, Problems and Plans, Louis W. Sullivan, M.D., President and Dean, Morehouse School of Medicine. (Address given to the meeting of the Psychiatric Institutes of America, June 11, 1985, in Atlanta, GA.)

A Salute to the Class of 1985 -- The Charter M.D. Class of the Morehouse School of Medicine, May 17, 1985.

14. Qualifications:

I feel that I am qualified for this position based on my education, my experience, and my training. I am confident that my demonstrated ability to solve complex problems, formulate and articulate policy and motivate people are added factors which will contribute to my success.

I have long been committed to improving health care to underserved segments of our country. That commitment led me to take leadership in establishing the Morehouse School of Medicine. My commitment to improved health and human services, for minorities, children and the elderly has caused me to become actively involved at the national, state and local levels to improve the efficiency and quality of care to these groups.

The CHAIRMAN. Thank you very much, Dr. Sullivan.

We will proceed with 15 minutes for the Chairman, 15 minutes for the Minority, and then we will go 10 minutes, rotating back and forth between the Majority and Minority, until everyone has had an opportunity to ask their questions. But there are obviously some matters that are of general interest to the committee, which I think both Senator Hatch and I will address.

First of all, I think it is important to note—or perhaps it is of greater importance and significance today than it might have been at another time—the very important and significant financial sacrifice that you and your family have made, or have indicated that you would be willing to make, in order to serve the public. At a time when there is a great deal of attention to those who have held office or who have been in high positions, whether in the Congress or in the Senate or in the Executive Branch, and have been able to effectuate very sizeable amounts of resources for their own personal gain, I think your commitment and willingness to undertake this at some very substantial sacrifice is something that probably does not need to be noted, but I think certainly ought to be noted by those whose interest and concern about this issue has obviously been heightened in recent times.

You have been far too generous in terms of rejecting those particular proposals, and I know that you have been willing to do that, but I would hope those who are interested and concerned both about the fairness of that situation to you and your family, as well as to the institution, and also are concerned about these various ethical issues, will have an opportunity to visit that.

I will not ask your comment on it, but this is just a view on this subject.

I would like to go into a number of areas. One of the matters in the news today, resulting in a program last evening, is the health of the food supply in America. This was the result of a consumer group publication, "The Dangers of Pesticides" on a variety of vegetables and fruits that are consumed by children in our society. And although I have not had an opportunity to review the consumer report itself, the news reports indicate up to 250 times greater amounts of these pesticides, some listed in that report, than the EPA has judged to be safe in terms of human consumption.

I am sure that many millions of families are concerned about that report, concerned about what it really means in terms of the health and safety of their children. I am wondering what assurances you could give to those families on the issue that was brought up in the report about the dangers of pesticides, herbicides and insecticides and the dangers they pose to children in the form of increased risk of cancer.

Dr. SULLIVAN. Thank you, Mr. Chairman.

While I did not see the program directly myself, I was informed about it last evening. And we have talked with our colleagues in the Food and Drug Administration, which has the responsibility for assuring the safety of the food supply of our Nation; and they have assured me of their great interest in following this very closely, to do everything we can to assure the continued safety of our food supply.

I think one of the issues that the Food and Drug Administration is concerned about is having, of course, sufficient manpower to do the evaluations that are necessary to assure that, as well as the fact that I believe the pesticide that was noted is one that is scheduled to be phased out by 1990, if I am correct there.

But I will assure you that if confirmed by the Senate, this will get my full attention, and we will do everything to assure the citizens of our country that we will be taking all of the measures necessary to assure the safety of our food supply.

The CHAIRMAN. Well, we are obviously very much aware of the short-handedness of the Food and Drug Administration. Senator Hatch is now considering this problem, and I am personally aware of it. We know we have a problem. But the real question is whether you are going to take the lead in trying to do something about it.

We hope to see a phase-out by 1990—of cancer causing pesticides. And I am just wondering if we can get some assurance from you that you are prepared to take this on as a leadership responsibility so that we can give assurances to American families that their health is going to be protected.

Dr. SULLIVAN. Oh, no question about that, Senator. I would give you that assurance unhesitatingly, that this is a major priority; we want to do everything to assure the American citizens of the safety of the food supply, and I will take that leadership role in so doing.

The CHAIRMAN. That is helpful and reassuring. I think people would have to ask, if it is going to be phased out by 1990, why shouldn't FDA halt the use of the substance today? And I would hope, as you are going to accept responsibility for leadership in terms of this issue, that if your staff determines that it is a current danger, you will let us know immediately; and secondly, if you have limitations, in terms of legislative authority, I would hope that you would come to us and the appropriate committees in the House of Representatives to provide you with that authority.

It is my impression that the FAA has that authority today. In any event we look forward to working with you, and keeping the public appraised as to what judgments and decisions you make in this area.

Let me go back to some of the points that I made in my opening statement about the numbers of Americans who do not have health insurance. Those numbers are increasing by about a million a year; 24 million are members of working families, have demonstrated their willingness to work eight hours a day, 52 weeks of the year, and yet they are playing roulette with their lives and with their children's lives in terms of serious illness, and not so serious illness and sickness in terms of the cost to them out of their paychecks.

I am sure you are familiar with the Johnson Foundation survey, which documents millions of Americans who are in need of health care but cannot afford it. These numbers are increasing.

We have millions of elderly people, 30 million of them, who are at risk in terms of the cost of long-term health care, either at home or in inpatient facilities.

What kind of assurance can you give the America people that these issues will have your attention and your energy and your in-

sights as a result of your being an administrator and a practitioner of medicine?

Dr. SULLIVAN. Yes, Mr. Chairman. Of course, I have long had an interest in access to health care for the poor and disadvantaged in our society and, in the training programs we have had for our students at the Morehouse School of Medicine, have tried to emphasize the responsibility that our graduates will have as leaders in their communities, in not only providing health care but also providing leadership to the community on those decisions concerning the provision of health services—how community resources, local, State and national, should be used.

So we are very much concerned with the 37 million uninsured or underinsured in our Nation. I think this is a problem that really demands response not only from the Federal Government but from the State and local governments and the private sector as well.

As you know, President Bush has proposed an expansion of Medicaid for mothers and young children that will address part of the problem; a Medicaid buy-in that also will help there. I am sure that much more needs to be done, and we will be looking at this problem and studying it intensively, and really working with you and members of this committee to come up with solutions. It is a very complex problem and a serious problem, but I an assure you that it will have our attention as we work to find solutions to this serious problem.

The CHAIRMAN. We certainly look forward to working with you on this issue. The problem I see with the Medicaid buy-in is that even if you increase the eligibility in terms of Medicaid, you are still going to require a very substantial contribution by someone else, whether it is going to be the employer, the State or the locality or the Federal Government. I have made the judgment that this is going to have to be a burden born by the private sector.

If this problem of the uninsured can be addressed in a different way, we want to hear about it. But at some time, we are going to have to make some judgments and some calls on this as to how we are going to resolve the problem and how we can contain medical care costs, which we certainly bloated.

We are also facing excess infant mortality—we are now 17th or 18th in the world, in spite of the fact that we have the best research capability in the world. In addition, we have not been willing to increase the salaries of some of the excellent scientists and researchers at NIH and FDA. This is going to require some attention.

By not dealing with these problems, the burden is falling on particular groups in our society, which I know you are very familiar with; and that, I know, must be very troublesome for you.

Let me just go quickly into the Medicare proposals. We have seen the Administration's proposal of a $5 billion cut. I have read your testimony over in the Finance Committee, and you say this is a $5 billion cut over the $8 billion increase.

I hear what you are saying in terms of trying to deal with the providers rather than the beneficiaries, and we know that the providers' payments have gone up 16, 18 percent per year over the last five years. And certainly, there ought to be some cost control in the way of provider reimbursements.

The problem I see with the Administration's proposal is that providers may simply collect more from the patients. Can you really do very much in terms of health care costs without prohibiting providers from passing along higher charges to patients when they receive lower payments from Medicare?

Dr. SULLIVAN. Yes, Mr. Chairman. The purpose of the budget plan for Medicare that has been submitted by the President is indeed not to cut services to beneficiaries, but really, indeed, to have the providers—that is, hospitals, physicians, nursing homes and others—actually become more efficient in the services they provide.

We do have a problem also, in some cases, with overutilization of services, which not only drives up the costs of services, but also exposes patients needlessly to procedures that may be of marginal benefit or no benefit at all and expose them to the risk of that procedure.

So we are looking at ways that we can get a handle on inappropriate utilization and try and correct that in the system, which would help in cost control, but also help in terms of avoiding unnecessary procedures.

It is a difficult and complex issue, I know, and I will certainly be working with my colleagues in the department.

The CHAIRMAN. My time is up.

Senator Hatch?

Senator HATCH. Thank you, Mr. Chairman.

Dr. Sullivan, let's just get one question out of the way right off the bat, and that is: Please express again your views on abortion, so that we can resolve that issue.

Dr. SULLIVAN. Yes, Senator Hatch. My position on abortion is as follows, that I am personally opposed to abortion; I have never participated in an abortion; I believe that it is disruptive of the best family values in our society. I am opposed also to Federal funding for abortion except in the case where it is necessary to save the life of the mother.

So I have tried to be as clear and as firm as possible on that, so that there will be no question as to where I stand on that.

Senator HATCH. Do you include exceptions for rape and incest as well?

Dr. SULLIVAN. Yes.

Senator HATCH. Do you have any opinion with regard to the issue of *Roe* v. *Wade*?

Dr. SULLIVAN. Yes. I am in accord with President Bush's position in that I would welcome a court decision overturning *Roe* v. *Wade*, yes.

Senator HATCH. On Title X, do you have any comments to make there? That is the family planning authority.

Dr. SULLIVAN. Yes. I support the department's position which indicates that there should be no funding of Title X programs for abortion; that Title X is intended to be family planning, which means a number of other activities encouraging our young people to postpone sexual involvement. But abortion has not been considered to be part, really, of family planning.

Senator HATCH. With regard to fetal research, could you give us an account of your viewpoint there?

Dr. SULLIVAN. Yes. On the issue of fetal research—because this question was asked in the Finance Committee the other day—the fact is this has been a significant issue that has been the subject of a special committee convened, I believe, early last year by the Assistant Secretary for Health, that has advised the NIH Director concerning fetal research. There has been a moratorium on fetal research pending the results of that committee. That committee's report has been presented to the Director of the National Institutes of Health along with the recommendations from that committee. The Director's advisory committee at the NIH has forwarded it to the Assistant Secretary of Health for review. Eventually, it will come to the Secretary of the Department with its recommendations.

And because I have not seen that committee's report, and because of the many hours given by many individuals to this very difficult issue, I have felt that it would be appropriate for me to wait until I have been presented with that report, with all of the thought that has gone into it, before taking a position.

Senator HATCH. Thank you.

The Food and Drug Administration is one of the bright starts in our Government's constellation. It is also one of the most beleaguered agencies in Government. It is slow to approve drugs; it sometimes takes longer to approve new drugs than other countries; it is having terrific difficulty in maintaining skilled personnel; it is using antiquated equipment; and of course, its personnel are located in 23 sites around the Washington, D.C. area. To me, it is almost impossible to run an agency of that magnitude. Yet, FDA is charged with regulating 25 percent of all of the consumer products in this country, and many throughout the world, in assuring we have effective drugs and medical devices as well as safe foods and cosmetics.

There is hardly an entity in Government that has as much impact on the actual lives of everyone in our society. Do you have any suggestions as to how we might revitalize FDA—and I do not expect you to go into that in great detail—but do you agree with me it needs to be revitalized, and we need to start doing some things there?

Dr. SULLIVAN. Yes, Senator Hatch, I certainly agree with your premise that we need to strengthen the Food and Drug Administration and do everything possible to improve the efficiency of that agency. And I certainly am very much aware and concerned with the fact that within the Food and Drug Administration, as well as within NIH, as Senator Kennedy indicated earlier, we are having difficulty attracting and retaining first-rate scientists because of the fact of the tremendous gap in income that these scientists would earn in the private sector versus positions in the FDA or NIH and other Federal agencies.

I think this is an issue that has to be addressed. I do know, for example, that at NIH there has been great difficulty over the past ten years in the ability to attract top-flight scientists from the private sector into Government service.

So I am sure that this is a major factor that is required.

Beyond the personnel issue, however, we certainly do need to work to be sure that we provide the FDA with the facilities and

equipment that is needed so that the workers there can carry out their jobs effectively in protecting the health and the drugs that are taken by the American people.

So I am very aware of that and very concerned about it. Obviously, that issue, along with many other issues that we are concerned with, have to face the realities of our budget constraints. But I do believe that this is something that does demand high priority, and I intend to give it that priority.

Senator HATCH. That is great. I notice that you do have quite a bit of Government experience, especially at NIH and FDA. And I have to commend you—I do not know that I have seen a better biography and resume of anybody. You have really accomplished a lot in your lifetime, and we are looking forward to you accomplishing a lot at the Department of Health and Human Services. But as a followup to that question, Dr. Sullivan, I would like to ask you and our Chairman, Senator Kennedy, to join me on a tour of FDA facilities in the near future. I think it would be an eye-opener for you as it was for me to see the working conditions under which we expect our top scientists in this very important agency to work.

And, FDA, of course, is not alone in this problem, as you have brought up. The National Institutes of Health, the Alcohol and Drug Abuse, and the Mental Health Administration are also having a difficulty time retaining top scientists and basically recruiting good people for their particular agencies. Is it possible that maybe you would join us on a tour like that?

Dr. SULLIVAN. I would be very pleased to do so, Senator.

Senator HATCH. I think if the three of us did that, we could really bring attention to just how important these areas are. This may help you in your quest to get this imbalance that you have spoken of brought back into balance.

I am an ardent supporter of disease prevention and health promotion activities. One area, of course, of my focus has been on the adverse health effects of smoking. In fact, I will be cosponsoring a bill with Senator Lautenberg to ban smoking in airplanes in this country. I have had countless flight attendants tell me, "Please, get it banned. We feel like we are smoking all the time, and we are getting respiratory problems and other problems that we really feel we should not have to put up with." It is affecting passengers as well.

Each year in this country, approximately 400,000 people die prematurely as tobacco users, and mainly because of their addiction to tobacco. The ranks of users are growing, especially among our Nation's youth, minorities and women. America's children addicted to cigarettes are expected to top one million, and the statistics for smokeless tobacco are even worse. So that excess tobacco use among minorities accounts in part for their increased rates of cancer, increased rates of heart disease and, of course, shorter life-expectancy.

And while there are a growing number of users of tobacco, 1.5 million Americans have been able to break their habit.

Could you just give us your ideas about what we Americans might do to break this hold that tobacco seems to have on our society?

Dr. SULLIVAN. Yes, Senator Hatch. Let me first agree with you in expressing concern about the adverse effects of tobacco in our society, and certainly, the disproportionate effect that tobacco has on our minority communities, our black and Hispanic and other minority communities.

As you know, I have been a member of the National Cancer Advisory Board for the past two years, since May of 1986, and this has been a subject of great concern to the members of that board, which oversees the activities of the National Cancer Institute. And as a result of an initiative that I presented to the board in the fall of 1986, we have initiated what is called a National black leadership initiative on cancer, which is a program designed to better educate the black community about the adverse effects of smoking and other tobacco products and, as you have noted, the disproportionate effect that tobacco has on these communities.

As a result of this initiative, we have held workshops in eight of our largest metropolitan areas around the country with black leaders in those communities—not simply health professionals, but laypeople as well—clergy, businesspeople, et cetera—so that we believe that a much stronger educational effort, advising our citizens about the adverse effects of tobaco indeed is needed.

We certainly support efforts of those individuals who are addicted to tobacco or nicotine, we certainly support more efforts to expand programs to help them break their addiction because, as you have noted, the adverse health effects not only so far as cancer, but heart disease and number of other disorders, is well-known in the medical community. So we fully support activities designed to try and arrest this problem that really is taking such a severe toll in our communities in general and certainly in our minority community.

Senator HATCH. Thank you very much.

Mr. Chairman, I have a few more minutes left, but why don't we stop for Senator Nunn.

The CHAIRMAN. We are delighted to welcome the Senator from Georgia, Senator Nunn, who has had a long-time relationship with the nominee, and who has come here to speak in support of Dr. Sullivan for the position of Secretary of Health and Human Services.

We are delighted to have you. I think all of us are aware of the pressures on your time these days, so we are grateful for your taking the time to join with the committee today.

We look forward to your comments, and we will put them at the beginning of the record at the appropriate place.

STATEMENT OF HON. SAM NUNN, A U.S. SENATOR FROM THE STATE OF GEORGIA

Senator NUNN. Mr. Chairman, I want to first assue our very capable nominee here that I did not come to put your nomination in jeopardy, and if you would like to move over a little bit from me and make sure you do not get in the same picture, I will be understanding of that. [Laughter.]

Mr. Chairman, I will just say two or three words about the nominee, and I would like my whole statement to be in the record. I do not want to interrupt your hearing.

But I have known Dr. Sullivan since 1975, when he came to Atlanta. I believe he came from your area of the world and had a very distinguished career there. He came down to Morehouse Medical Education Program. It was just getting under way, and it was one of the most challenging undertakings anyone could ever imagine. He did a superb job.

He is very highly regarded in our part of the country. He was there when the Morehouse Medical School went from two-year to four-year. I believe 75 percent of the doctors who come out of Morehouse now are going into primary care residencies. They serve from the Northeast to the West Coast in the ob-gyn, pediatrics, internal medicine and family practice fields.

The next Secretary of Health and Human Services has the difficult task of establishing our national priorities and allocating scarce Federal resources in the area of health care and social services. As a health care professional, Dr. Sullivan will bring to that important post a thorough knowledge of the health care problems our Nation faces including AIDS, infant mortality, heart disease, cancer, and drug abuse.

If Dr. Sullivan's track record is any indication of his ability, I am confident that he will be an effective advocate for the most pressing health and social service needs of our country.

Particularly, Dr. Sullivan knows about the problems of the uninsured. We have almost one million uninsured Georgians. We have, of course, nationally some 37 million uninsured, and we have got to deal with that problem.

Dr. Sullivan knows about health manpower areas that have shortages. We have 66 counties in Georgia that have shortages in health manpower. We also have 69 counties in Georgia that have no obstetricians.

He knows about the drug problem facing our country.

So I am here to support Dr. Sullivan very vigorously. I think he will do a very fine job, and we are proud that he comes from our State.

The CHAIRMAN. That is an excellent commendation, and we welcome that very much, Senator Nunn. Thank you very much for taking the time to come over here; we appreciate your presence.

We will include the full statement in the record.

Senator NUNN. Thank you, Mr. Chairman.

[The prepared statement of Senator Nunn follows:]

INTRODUCTORY REMARKS

CONFIRMATION HEARINGS OF DR. LOUIS SULLIVAN

Mr. Chairman, members of the Committee, I am delighted to be here today to introduce Dr. Louis Sullivan. I am pleased that the nation can now benefit, as Georgia has, from this articulate, compassionate health care advocate.

Dr. Sullivan left a successful career in Boston in 1975 to return to his alma mater as dean and director of Morehouse College's Medical Education Program. Under his leadership, in a period of 3 years, Morehouse went from a two-year medical education program to a prestigious four-year institution. Its mission is to produce physicians who devote their lives to the primary care needs of the uninsured and the underserved.

Of the students who have graduated from Morehouse School of Medicine approximately 75% have gone into primary care residencies. They serve from the northeast to the west coast in the OB-GYN, pediatrics, internal medicine and family practice fields.

The next Secretary of Health and Human Services has the difficult task of establishing our national priorities and allocating scarce federal resources in the areas of health care and social services. As a health care professional, Dr. Sullivan

will bring to that important post a thorough knowledge of the health care problems our nation faces including AIDS, infant mortality, heart disease, cancer and drug abuse. If Dr. Sullivan's track record is any indication of his ability, I am confident that he will be an effective advocate for the most pressing health and social service needs of our country.

One of the most disturbing concerns in the medical arena is the health problems of the uninsured and medically underserved. It has been estimated that there are 37 million uninsured in our country today. Of Georgia's 6 million citizens, approximately 15% (904,000) are uninsured. Sixty-six counties in Georgia are designated as Health Manpower Shortage Areas. This means that 18.5% of Georgians live in underserved areas. In addition, of our 159 counties, 69 do not have an obstetrician. In Georgia and at Morehouse School of Medicine, Dr. Sullivan has been actively involved in these issues and he will be able to draw on this experience as he develops responsible policies to address the needs of the uninsured and underserved in our entire nation.

Containing costs, particularly in the Medicare program, will dominate the health care agenda. As an administrator, Dr. Sullivan is aware of the importance of sound fiscal policies and, I believe, is prepared to work with Congress to find workable solutions to slowing the growth of this program.

The nominee and I have discussed the implications of drugs

in our society and the increased emphasis which must be placed on reducing the demand for drugs through effective treatment and education programs.

Dr. Sullivan's compassion, his experience, and his competence will serve him and the country well as he embarks on a new endeavor. I do not envy the challenges he will face during the next several years; however, I am confident that he will approach these challenges with the same vigor that is characteristic of his efforts in the past. I highly recommend Dr. Louis Sullivan to you as Secretary of the Department of Health and Human Services.

Senator HATCH. Mr. Chairman, could I just finish my last two questions?

The CHAIRMAN. Yes.

Senator HATCH. Dr. Sullivan, Senator Nunn's testimony was very supportive and helpful to you.

I will submit a question about child care and what your ideas are with regard to that. As you know, I am a strong proponent of doing the most intelligent thing we can do, and I hope you can help in that area—as well as other programs for children. Let us know what we can do to help with these programs for families and children on this committee, because of our jurisdiction. We can do a lot of good things if we have the right ideas. And, I think we can develop a very good bipartisan approach to this under our chairman.

I have a question from Senator Coats—he asked me to ask a number of them, but I am going to submit all of his questions in writing. Senator Coats' question is as follows: "This past year, the Senate entertained Floor debate on the issue of whether a spouse should have the right to know that his or her spouse has been infected with the AIDS virus."

Now, in light of the deadly nature of this disease, do you believe that a spouse should be notified when that particular spouse has contracted AIDS?

Dr. SULLIVAN. Well, Senator, this is a very critical issue that confronts our society on the whole issue of notification concerning infection.

Hopefully, the best approach would be voluntary notification by the spouse of his or her mate. I think that this is an area that our colleagues in public health are very much concerned about, that we need to do everything we can to encourage our population, our citizens, to be tested if they are at risk for this infection. And one of the concerns about mandatory notification or breach of confidentiality is that it may discourage individuals from coming in for such testing.

So we would certainly very much support and encourage individuals for voluntary notification. Beyond that, the issue of notification, I believe, is a State matter concerning the measures in the States.

The Department is looking at the whole issue of notification and what exists in our 50 States, and we certainly will be following this very closely.

Senator HATCH. If there is voluntary notification, would you agree that there should or should not be an obligation on the part of the physician to confirm or not confirm that particular notification?

Dr. SULLIVAN. Yes, certainly there is a responsibility on the part of the physician to do everything to protect the health of the population, yes.

Senator HATCH. All right. I would ask, Mr. Chairman, that the balance of Senator Coats' questions be placed in the record, and Dr. Sullivan can perhaps answer those before we go to the Floor; and also another set of questions which I have, and I understand other members of the Minority will be submitting questions; and then also, Senator Thurmond's statement for the record.

The CHAIRMAN. We will include the statements as part of the record, and then we will inquire of the nominee in written form on behalf of the members who do have questions and are unable to be here with us this morning, and hopefully we will get as early a response as possible. At any rate, all responses to subsequent questions will appear at the end of the printed record.

[The prepared statement of Senator Thurmond follows:]

STATEMENT BY SENATOR STROM THURMOND (R-S.C.) BEFORE THE FULL SENATE LABOR AND HUMAN RESOURCES COMMITTEE REFERENCE CONSIDERATION OF SECRETARY OF HEALTH AND HUMAN SERVICES NOMINEE, DR. LOUIS WADE SULLIVAN, FEBRUARY 27, 1989, 10:00 AM, SD-430.

MR. CHAIRMAN:

I COMMEND YOU FOR SCHEDULING THIS HEARING ON THE NOMINATION OF DR. LOUIS WADE SULLIVAN TO BE SECRETARY OF HEALTH AND HUMAN SERVICES. I AM LOOKING FORWARD TO HIS SWIFT CONFIRMATION.

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES HAS A BUDGET WHICH IS SECOND ONLY TO THE PENTAGON'S AND IT IS CHARGED WITH THE RESPONSIBILITY OF ADMINISTERING PROGRAMS WHICH PROVIDE VITAL SERVICES TO OUR NATION. I AM CONFIDENT THAT PRESIDENT BUSH HAS MADE A WISE SELECTION IN HIS CHOICE OF DR. SULLIVAN TO HEAD THIS IMPORTANT DEPARTMENT.

MR. CHAIRMAN, DR. LOUIS SULLIVAN IS WELL QUALIFIED TO HOLD THE DEMANDING POSITION OF SECRETARY OF HEALTH AND HUMAN SERVICES. A NATIVE OF ATLANTA, GEORGIA, HE GRADUATED MAGNA CUM LAUDE FROM MOREHOUSE COLLEGE AND RECEIVED HIS M.D. DEGREE CUM LAUDE FROM BOSTON UNIVERSITY. HE COMPLETED HIS INTERNSHIP AND MEDICAL RESIDENCY AT NEW YORK HOSPITAL, CORNELL MEDICAL CENTER. DR. SULLIVAN ALSO SERVED A RESIDENCY IN GENERAL PATHOLOGY AT MASSACHUSETTS GENERAL HOSPITAL, AFTER WHICH HE BECAME A RESEARCH FELLOW IN HEMATOLOGY AT THE THORNDIKE RESEARCH LABORATORIES OF THE HARVARD MEDICAL SCHOOL AT THE BOSTON CITY HOSPITAL.

LOUIS SULLIVAN HAS BEEN AN ASSISTANT PROFESSOR OF MEDICINE AT THE NEW JERSEY COLLEGE OF MEDICINE, AND SUCCESSIVELY, AN ASSISTANT PROFESSOR, ASSOCIATE PROFESSOR, AND FULL PROFESSOR OF MEDICINE AT THE BOSTON UNIVERSITY SCHOOL OF MEDICINE. WHILE IN BOSTON, DR. SULLIVAN BECAME CO-DIRECTOR OF HEMATOLOGY AT THE BOSTON UNIVERSITY MEDICAL CENTER, WHERE HE CONTINUED HIS RESEARCH IN THAT AREA.

IN 1975, DR. SULLIVAN BECAME THE FOUNDING DEAN AND DIRECTOR OF THE MEDICAL EDUCATION PROGRAM AT MOREHOUSE COLLEGE. WHEN THE MOREHOUSE SCHOOL OF MEDICINE BECAME INDEPENDENT OF MOREHOUSE COLLEGE IN 1981, DR. SULLIVAN WAS NAMED ITS PRESIDENT. SINCE 1985, HE HAS SERVED WITH DISTINCTION AS PRESIDENT OF THAT INSTITUTION OF MEDICAL LEARNING.

DR. SULLIVAN'S ACADEMIC ACHIEVEMENTS HAVE BEEN RECOGNIZED THROUGH HIS INDUCTION INTO THE ALPHA OMEGA ALPHA MEDICAL HONOR SOCIETY, AS WELL AS PHI BETA KAPPA. HE HAS ALSO SERVED AS A MEMBER OF THE INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMY OF SCIENCES, THE CANCER INSTITUTE'S NATIONAL CANCER ADVISORY BOARD, AND AS VICE CHAIRMAN OF THE COMMISSION ON HEALTH AND HUMAN SERVICES OF THE SOUTHERN REGIONAL EDUCATION BOARD. ADDITIONALLY, HE HAS BEEN HONORED BY NUMEROUS OTHER PROFESSIONAL AND CIVIC ORGANIZATIONS.

MR. CHAIRMAN, LOUIS SULLIVAN HAS DEMONSTRATED HIS EFFECTIVENESS AS AN OUTSTANDING PHYSICIAN, TEACHER AND ADMINISTRATOR. HE IS A MAN WHO IS SENSITIVE TO THE NEEDS OF THE

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UNDERPRIVILEGED AND ELDERLY OF OUR COUNTRY. DR. SULLIVAN IS A DEDICATED LEADER WHO POSSESSES THE EXPERTISE NECESSARY TO CARRY OUT PRESIDENT BUSH'S POLICIES AT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES. I URGE MY COLLEAGUES TO JOIN ME IN SUPPORTING THIS NOMINATION.

Senator HATCH. Thank you.

If I could just say one other thing, Mr. Chairman, and that is that I have appreciated the very good responses that Dr. Sullivan has made today. I think you have done a lot to clear up some of these areas, as I think you have in the past. And there is no real reason for people to be as concerned or as upset as perhaps some have indicated in the past.

I think your vote in the Finance Committee has shown a great deal to the whole country as to just how well-accepted you are here. And I believe the members of this committee will vote for you on the Floor as well. We look forward to having that occur tomorrow.

Dr. SULLIVAN. Thank you, Senator.

The CHAIRMAN. Senator Harkin?

Senator HARKIN. Thank you, Mr. Chairman.

I would like to just ask that my statement be made a part of the record.

The CHAIRMAN. Yes, it will be made a part of the record.

OPENING STATEMENT OF SENATOR HARKIN

Senator HARKIN. I welcome Dr. Sullivan to the Committee.

I have just basically three areas that I would like to cover, Dr. Sullivan. First of all is our commitment to Americans with disabilities.

In his State of the Union Address, President Bush spoke of his commitment to ensuring that Americans with disabilities become part of the economic mainstream of society. I will quote what President Bush said in the State of the Union Message.

> To those 37 million Americans with some form of disability, you belong in the economic mainstream. We need your talents in America's work force. Disabled Americans must become full partners in America's opportunity society.

During his campaign, President Bush also spoke of his commitment to civil rights protections for persons with disabilities parallel to those which minorities enjoy. In that context he endorsed the principles of the Americans with Disabilities Act, which I will be introducing in the near future we are working on that right now.

Dr. Sullivan, do you share the basic principles espoused by the President in these statements, and can we look forward to your support as we proceed with our work on the Americans with Disabilities Act? Have you taken a look at the bill that was introduced last year which will form the basis, again, for the bill introduced this year?

Dr. SULLIVAN. Thank you, Senator Harkin.

On the issue of the bill, I have not had an opportunity to actually read the bill or examine it. But let me assure you that on the principles that the bill addresses, you have my full interest and support and commitment. I fully agree with the desirability, indeed the necessity, for our country to fully harness the capabilities and contributions that can be made by our citizens who have disabilities, to not only their own lives, but also to the benefit and productivity of our country. So I certainly support those principles fully and firmly and will work with you and the members of this committee and the Congress to do everything we can to ensure the

fully participation of our citizens with disabilities in the mainstream in our society.

Senator HARKIN. Thank you very much, Dr. Sullivan.

The next area I would like to get into is something which Senator Nunn was just talking about. When he was describing rural Georgia, I thought he was talking about Iowa there for a second.

It is estimated that as many as 600 rural hospitals will close in the next few years, at least partly as the result of the differential in the rate of reimbursement to rural and urban hospitals under the Medicare prospective payment system.

In Iowa 75 percent of the hospitals in my State are classified as rural for Medicare reimbursement purposes, and they are reimbursed at a rate approximately 12 to 13 percent less than those compared with urban hospitals. And sometimes, these hospitals are just not very many miles apart. So the rural hospitals suffer from less of a reimbursement rate than the urban hospitals.

Many hospitals tell me that Medicare reimbursement often does not even meet their expenses. And in fact we have one rural Iowa hospital that has recently gone into receivership.

Well, legislation has been introduced that will eliminate the differential between Medicare prospective payment rates for urban and rural hospitals in favor of a single national rate for all hospitals.

When this came about a few years ago, I am sure you know, Dr. Sullivan, it was assumed, incorrectly—I do not know how they ever assumed this—that rural hospitals would have lower operating expenses than urban hospitals. Well, quite frankly, just the opposite has turned out. The labor rate differential is not that great if it even exists at all, because there is too much mobility involved, so that really they have to pay the same thing in rural hospitals for their practitioners, their primary care practitioners, their nurses and others than they have to pay in urban hospitals.

Secondly, it was assumed that rural hospitals could get things cheaper, but it has turned out that is just the opposite. Urban hospitals join together, they buy in large quantity, they get it at a cheaper price while a small rural hospital buys in small quantities, and they have to pay more for it.

So just the opposite has turned out, and yet it is the rural hospitals that are being penalized under this system.

As I said, legislation is in now to have a single national rate. I am wondering what your position is on this. Would you support this legislative attempt to remove the inequity in reimbursement rates for urban and rural hospitals?

Dr. SULLIVAN. Well, Senator Harkin, I am certainly very familiar with the problem of rural hospitals. The medical school I have headed has had as its major impetus training physicians for both inner city and rural practice, and part of that training involves preceptorships with physicians in rural communities.

One hospital we were affiliated with is in Tuskegee, Alabama, some two hours away from Atlanta, in Macon County, Alabama, where the population, I believe, is approximately 70 percent black, and many of the health indices in that population are really like the indices you would find in Central America or in some other Third World countries—an infant mortality rate higher than 40

infant deaths per thousand live births; very high incidence of hypertension and deaths from stroke, heart disease, et cetera.

So we are very much concerned about the problems that the rural hospitals and rural physicians face. I believe the department has made efforts to try and close that reimbursement gap between rural and urban hospitals. I realize that that activity still leaves much to be desired here, and I certainly will be working with my colleagues in the department to help address this issue.

On the specific legislation that you mention, I think I would really have to wait and learn more about that, because as you know, the very real problem that we are facing overall, of course, is not only the budget deficit, but the escalation in medical costs, and we want to do everything we can to correct the problem of the rural hospital but in a way, hopefully, that would not cause greater stress on our economy.

But I can assure you that I will be looking very closely at that problem, and working with you and the other members of this committee in trying to address that issue.

Senator HARKIN. Well, I appreciate that, but one phrase you just used, I hope inadvertently, and that is that we have to worry about undue impact on our economy, because as you point out, we have a "Third World" out there right in our midst, right here in rural America—people who are out there without health care. I do not remember how many counties Senator Nunn said did not have an obstetrician; kids are being born without having prenatal care in those rural areas. We know that the infant mortality rate is as high and higher, sometimes, in rural areas than it is in the inner city areas.

So the underlying determinant cannot be the impact on our economy. Certainly, we all have to make cuts. But I guess it disturbs me when I see a disproportionate share of the budget cuts coming out of rural America, whether it is in farm programs or reimbursement rates to rural hospitals, health care in rural areas, transportation in rural areas. There just seems to be an attitude that if you live in rural America, if you do not like it, move, go to the city. That seems to me to be a very callous kind of an attitude toward those millions of Americans who want to live in rural America.

Again, I think there should be a single reimbursement rate—but if it is not that, it has got to be something. And I guess what I want to plumb a little further with you is your determination to make a very rapid change in the way these rural hospitals are treated.

For example, in the budget that we have before us, we have about $3.4 billion in cuts out of Part A and Part B; $2.4 billion comes out of Part A, reimbursement rates to hospitals, and $1 billion comes out of the Part B that goes to doctors.

Well, when I look at the graphs, though, of the past increases in the payments, from 1983 to 1988, Part A has gone up by one-third; from 1983 to 1988, Part B, physician services, has doubled. Then we look at the projections. Under the current law, or even under the proposed law—proposed or current—from 1989 to 1994, Part B doubles again, either under current law or proposed law, it doubles

again. But under the proposed law or the current law for Part A, for hospitals, it goes up again by about one-third.

And yet two-thirds of the cuts proposed in the budget come out of Part A, not out of Part B. But it is Part B where the increase is taking place. It is also Part B, that is three-fourths funded from general revenues. And yet Part A is funded from the trust fund, which is solvent.

And if you cut that much out of Part A reimbursement rates to hospitals, and you see that rural hospitals are getting cut more than urban hospitals, then the effect is magnified for rural hospitals.

So the proposed cuts in Part A, while it will affect all hospitals, urban and rural alike, have a much greater impact on rural hospitals.

So again, I guess what I want to hear from you is that something is going to be done about this, rapidly, because I can tell you right now a lot of these hospitals will go into receivership; they will go out of business in rural areas, and the problem will get worse unless we address it immediately.

Dr. SULLIVAN. Well, Senator Harkin, let me assure you that I have a very real, very genuine concern about the problems that you have alluded to. But as I said earlier, it is a complex problem that I really think that I would honestly have to say that since I have not really had the opportunity, not yet being confirmed by the Senate, of participating in detailed budget discussions, that I could only say that this is an issue that I will be working with my colleagues in the department and with the President and his colleagues as rapidly as possible.

Part of the reason, I am sure, for the projected increase in the Part B or physician services has been the emphasis that we have put on shifting services from the hospital to the ambulatory setting, including physicians' offices. So I think we all recognize that we have been fairly severe on the hospitals, perhaps more so than on the physicians and other providers. But we are concerned about appropriate utilization of services, including those given in physicians' offices and clinics and in the ambulatory setting.

We need to find and are looking to find ways that we can get a handle on that, also, because as I mentioned earlier, it is not only controlling costs but making sure that services that are rendered are appropriate and result in the likelihood of benefit to the individual and are not exposing them unnecessarily to procedures.

But I do share your concern about this. As Senator Nunn mentioned, I have travelled all over the States of Georgia and Alabama, as well as visited other States as well, and we are very much concerned and committed to addressing the problem of the rural hospitals.

I think that before I could go beyond that, I would have to really get into the analysis with my colleagues in the Department and work with the President and others before we could come up with a better and more clear answer to that.

Senator HARKIN. Dr. Sullivan, in my other role as the chairman of the Health and Human Services Appropriation Subcommittee, you will be, I think, our lead-off witness in early April. You will have been confirmed by that time and will have been in the job for

almost a month. And I just want you to know that this is an area that I will be covering in more detail with you, concerning the appropriations process, the moneys I just spoke about, and what we are going to do about balancing those off this year.

So again, at that time, we will talk about it more in depth.

Thank you very much, Dr. Sullivan.

Dr. SULLIVAN. Thank you, Senator.

Senator HARKIN. Thank you, Senator.

[The prepared statement of Senator Harkin follows:]

Tom Harkin

OPENING STATEMENT FOR LABOR AND HUMAN RESOURCES COMMITTEE
COURTESY HEARING WITH DR. LOUIS SULLIVAN
FEBRUARY 27, 1989

DR. SULLIVAN, I WOULD LIKE TO ADD TO THE STATEMENTS OF MY COLLEAGUES THAT I ALSO LOOK FORWARD TO WORKING WITH YOU, NOT ONLY IN MY CAPACITY AS A MEMBER OF THIS COMMITTEE, BUT AS THE CHAIRMAN OF THE LABOR-HHS-EDUCATION APPROPRIATIONS SUBCOMMITTEE. YOUR DISTINGUISHED CAREER, MOST RECENTLY AS PRESIDENT OF MOREHOUSE SCHOOL OF MEDICINE, HAS CERTAINLY PREPARED YOU FOR YOUR PRESENT CHALLENGE, AND I BELIEVE YOU WILL MAKE A FINE SECRETARY OF HEALTH AND HUMAN SERVICES.

YOU ARE IN A UNIQUE POSITION TO EFFECT POSITIVE CHANGES TO IMPROVE THE HEALTH CARE OF ALL AMERICANS BY TAKING STEPS TO REDUCE INFANT MORTALITY, PREVENT AND TREAT DISEASE BY RENEWING OUR COMMITMENT TO BIOMEDICAL RESEARCH, AND TO STRENGTHEN THE MEDICARE AND MEDICAID PROGRAMS SO THAT THE POOR AND THE ELDERLY DO NOT SUFFER AS A RESULT OF EFFORTS TO REDUCE THE FEDERAL DEFICIT.

WHILE I KNOW YOU WILL BE TESTIFYING BEFORE MY APPROPRIATIONS SUBCOMMITTEE IN EARLY APRIL AND WE CAN GET INTO THE DETAILS OF THE HHS BUDGET PROPOSALS THEN, I DO HAVE A FEW QUESTIONS I WOULD LIKE TO RAISE WITH YOU TODAY.

The CHAIRMAN. There are not many times that I differ with my good friend from Iowa, but I would say, we have urban and rural hospitals in our own State of Massachusetts that we suffering financially.

When young people go to medical school and into high paying subspecialties to pay off their educational debt, they are not choosing to practice in primary care settings. When the financial structure of the whole Medicare program is to give higher reimbursements to specialists as compared to primary care providers, you are going to have trouble finding doctors to go to rural America. If you do not provide educational opportunities so that they can update their knowledge similar of their colleagues who live in urban areas, I do not think you are going to recruit and retain physicians in rural America.

It is a complex and difficult issue, and as the Senator knows, 15 years ago we addressed these issues. Reimbursement is an issue. You also have got to look at utilization, how many hospital beds we empty. You have some empty beds in hospitals in metropolitan areas, in my State. The problem is not confined to rural areas.

None of us expect you to oversee every hospital. Hosptials are reimbursed one way on one side of the street and another way on the other. I am sure you have heard that from several Senators—if you have not, you are going to.

Dr. SULLIVAN. I have heard it, Senator.

The CHAIRMAN. We need financial incentives to get physicians and other providers in areas which are underserved. We initiated the National Health Service Corps under Senator Magnusen, and myself, and I am sure it is supported by Senator Harkin. We defined underserved areas in rural as well as in urban communities. We were beginning to get physicians to practice there. But the legs were cut out from under that program.

So I certainly agree with my friend that we need to get medical care services into rural areas. When a child is born, whether it is a healthy child or an unhealthy one, it should not depend on what part of this great country they are born in, or the size of the wallet or the pocketbook of their parents—we are preaching to the converted, I know, both of us are, on this.

But I think we want to do what is right in terms of fair reimbursement for both hospitals and medical services.

I do not know whether Senator Harkin was here during our earlier discussions if they cut back on reimbursement to providers, unless they are prohibited from doing so, they are going to get additional money from patients who live in rural and urban areas. In terms of the total cost to the system, you may be able to make some progress in terms of reducing payments from Medicare. But the fact is that the impact on consumers will not change.

Senator HARKIN. Well, I cannot disagree with what you say, except to point out that in many rural areas, these hospitals are in extremis right now. Another whack at the reimbursement rate is going to push them over.

And sure, we have tried a lot of things—utilization; we have increased the swing beds; a lot of our rural hospitals now are able to swing their beds from acute to long-term care; a lot of these hospitals are talking about utilizing them for daycare services, for other

kinds of activities. But these are some things that take two or three years to do, and if they have got to close their doors this year because they go into receivership, then we've got a problem.

I am just saying that there are a lot of them out there that are right on that edge.

The CHAIRMAN. I do not differ with the Senator in urging Dr. Sullivan to review this issue, so that quality of health care is not reduced, in either rural or urban areas.

A number of years ago, we tried to initiate a Federal cost containment program, but we were not successful. Critics said we should leave it up to the States, and a number of States did design efforts at cost containment, to squeeze some of the fat out of the system. Other States did not.

In some of these States which have had cost containment programs and have really squeezed down, and additional cuts we sought in hospital payments, you are going to run into a very, very difficult problem.

I know you are very familiar with these issues Dr. Sullivan, but we do get worked up on some of these matters.

Dr. SULLIVAN. Well, Senator Kennedy and Senator Harkin, I can assure you that this is something we are very much concerned about. Again, I would certainly be misleading if I did not say that these are complicated issues; that there are a number of factors that do impinge there. But we are committed to the basic premise that all of our citizens should have access to health care services of high quality. At the same time, we are obviously, as a Nation, with a number of things we would like to do, constrained by budgetary factors—but that does not mean we intend to sit back and do nothing. I think we want to find areas where we can increase efficiencies, where we may be able to save by changes in or elimination of regulations, paperwork, et cetera. We want to make sure we do not have inappropriate utilization.

So there are a whole host of things that we need to look at, and I cannot tell you just how much of the problem will be addressed by that. We may not be able to address it all by that, and we may very well need to do a number of other things. But certainly, we will be looking at this issue and working with you and with my colleagues in the department to try and address the rural health care problem along with the problem of inner city hospitals as well.

I mentioned the hospital in Alabama that closed. We also had an inner city hospital that closed a year ago in October as well. The common denominator with these hospitals is that they were both small. And indeed, the overhead costs in a small facility with the broad array of services it needs to provide may be higher than in a larger facility.

But we will be looking at this issue and working with you to try and find solutions.

The CHAIRMAN. Let me mention one other matter that I am sure Senator Harkin is familiar with, and that is that hospital reimbursement rates have not significantly increased in five years. In my State, they are reimbursed using the same formula from five years ago. As I understand, there is going to be a review of hospital reimbursement rates in 1991. This is going to be something enormously important to hospitals around the country.

I think we both feel, as you can tell, that this has enormous consequences and is an extraordinarily complicated issue. But I would underline what Senator Harkin has mentioned, and that is the emergency nature of it. It has reached crisis proportions in rural areas, and we have seen it also impact hospitals that are extremely well-run. We have one hospital in Massachusetts, probably the best run in terms of the various hospital associations' criteria. They have 67 percent of their beds occupied by Medicare patients. It has been considered to be one of our most efficient hospitals. They are just about to go under. As I understand it, once a hospital has over 61 percent Medicare patients—that is the rough rule, a point or two either way—they are at risk financial.

I am glad that you have thought about this problem as much as you have and are going to give it your full attention. And I would just underline that I am very hopeful that we are going to be able to get action on the Americans with Disabilities Act. It is a complicated piece of legislation, but it is one of our top priorities in this Committee. We have found, if we are able to work some of these matters out prior to the time a bill is introduced, it saves us time down the road.

But we want you to know, as I am sure you do, the strong priority we give to that legislation. We have had the chance to talk to President Bush personally about it, as well, and he is very much aware of it, and we are looking forward to having, hopefully, his strong support for that legislation.

I have just a couple other things, Doctor Sullivan. I will submit some other questions for the record. We have had a very good contribution, as we have many good contributions from my colleague from Utah, Senator Hatch, with regard to home health care on the AIDS issue.

We passed an authorization bill last year, but we were unable to gain funding for those particular AIDS programs. There was some increase in terms of research, but I think we have enough evidence about home health care for people with AIDS in California, as compared to other places where it is not available, in terms of total cost-savings to the system.

So I would draw that to your attention, and we will be visiting with you later on on that particular question.

Did I understand from Senator Hatch's questions about the extension of the Titles X and XX that, outside of those questions about using any of those facilities for abortion, you do not have trouble with the reauthorization, or do you encourage the reauthorization of Titles X and XX, given the kinds of protections that you have mentioned here?

Dr. SULLIVAN. Yes, Senator.

The CHAIRMAN. Okay. That is helpful.

You are aware of some of the problems we are facing in terms of biomedical research and some of the allegations of scientific fraud. That is an issue that has been of concern to a number of different committees here, and we hope to be able to work with you, certainly, to deal with the problem.

We did not really have much of a chance to go over the issue of borrowing by medical students and the impact of increasing indebt-

edness on these students in terms of specialty choice. Perhaps you would like to say a word on that.

Dr. SULLIVAN. Yes, Senator Kennedy. This is an area that really is of great concern to us, as well as, I believe, virtually everyone in medical education in the country.

As you know, our medical students and other health profession students—those in nursing, dentistry, et cetera—have had over the last decade or more to rely much more so on borrowing to finance their health professions education than on grants. As a result of that, as you have noted previously, the student indebtedness has escalated tremendously. I know that the average medical student graduates now with an indebtedness of more than $40,000, and some with debts of over $100,000 at the time they graduate.

The existence of that debt, regardless of the other intentions of the students, that debt does tend to drive students into the higher-paying specialties rather than into the primary care fields, and also drives them toward affluent communities rather than low-income communities.

So we are very much concerned about that, and as you noted, that also impinges upon the question of availability of health services in low-income and rural communities.

So that is a severe problem. It, I think, is going to require a lot of effort to address that. As you know, the number of medical students, applicants to medical schools, has declined by about one-third over the past eight or nine years. Part of that, we know, is because the high cost of medical education tends to cause some applicants to select themselves out of the process. So this high indebtedness that our students have does have many adverse effects throughout the system, and we are very much concerned about that.

The CHAIRMAN. I hope also, when you are looking at some of the matters raised here in the hearings, that you will really give a hard look at Medicare reimbursement and overutilization. In a number of areas, there is higher reimbursement for a cesarean section as compared to a natural newborn delivery, and you will find some areas of the country that have three, four, five times as many C-sections as natural births. There are health implications from this, that hopefully the various medical professional groups are reviewing, but there are enormous cost implications with regard to these matters as well.

There are more and more studies of the appropriateness of various medical treatments, costly treatments, that are certainly well worth looking at.

You have been very generous with your time, and we appreciate it very much. We did not get into a wide range of other issues which we, you and I, had an opportunity to talk about, but I know of our deep interest.

I want to again express our very sincere appreciation for the time that you have spent with all of us, talking with us about these issues privately and for the statements you have made, the appearances that you have made before this committee in the past, the help you have given our committee on some of these issues. You are not only an expert witness, but a very important national leader and a resource.

I want to express our appreciation for your responses this morning. We look forward to, I predict, a unanimous vote in the United States, and I will be proud to cast one of those votes.

Dr. SULLIVAN. Thank you very much, Senator Kennedy.

The CHAIRMAN. We will include in the record at this point the responses of Dr. Sullivan to subsequent written questions submitted by members of the committee and any additional statements received.

[The material referred to follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington D.C. 20201

APR 27 1989

The Honorable Edward M. Kennedy
Chairman
Committee on Labor and Human Resources
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Enclosed are responses to questions submitted to Secretary Sullivan following his confirmation hearing before the Labor and Human Resources Committee. All of the submitted questions have been responded to with the exception of question 2 from Senator Simon. Experts in our Freedom of Information office are reviewing this issue, and a response will be sent to you as soon as possible under separate cover.

Should you have questions about this material, or need further information, please do not hesitate to contact me.

Sincerely yours,

Kay Holcombe

Kay Holcombe
Associate Director for
Public Health Legislation
Office of the Assistant
Secretary for Legislation

Enclosure

SENATOR KENNEDY

1. Q. In 1985, then Secretary Margaret Heckler released the Report of the Secretary's Task Force on Black and Minority Health. The Task Force estimated that using mortality data for White Americans, nearly 60,000 excess deaths occur among Blacks each year attributable to six disease categories. What new programs or initiatives can we look forward to from DHHS to address this critical problem.

What sort of legislative initiatives would you suggest to reduce this disparity?

A. In order to learn the best way to combat the significant health related problems affecting Blacks and other minority groups disproportionately, the Department has held conferences and met with minority groups and representatives to identify and define these problems and develop strategies for addressing them. In addition, national health surveys have been expanded to include the collection of data on the health status and problems of minority groups. Some other important Departmental efforts are outlined below:

- The AIDS Education/Prevention Grant Program provides grants to minority community-based and national organizations to develop effective alternative approaches to reach minority populations.

- A consensus meeting to examine issues regarding violence in minority populations and to assess intervention methods was held in February.

- A conference on Financing Health Care for Minorities is planned in May 1989 to discuss major issues in financing and access, and to consider alternatives for overcoming barriers to financing and delivery of care.

- NCI is undertaking investigations of tumors that occur excessively among Blacks to identify the risk factors for these malignancies in these populations and the reasons for the excess cancer incidence among Blacks.

- The NHLBI is supporting research to better understand the contributions of coagulation proteins, adhesion molecules, endothelial cells, and membrane changes to the pathophysiology of infarction during pregnancy in sickle cell disease patients.

- Recent NHLBI supported studies have shown that Blacks have substantially greater blood pressure responses and blood pressure reactivity when subjected to physical and cognitive stressors while showing no significant difference in heart rates. These studies along with other studies among Blacks suggest that the greater hypertensive burden on Blacks is due to a combination of genetic and environmental factors. These results should result in more effective approaches to reducing that excess burden.

- The CDC Preventive Health and Health Services Block Grant program supports States' diabetes control programs that have been specifically targeted towards minority groups.

- In 1990, the CDC Chronic Disease program funds will be used to develop and deliver effective interventions to reduce risk behavior among minorities and other currently underserved groups. Such risk factors as smoking, excessive dietary fat consumption, and lack of physical activity will be addressed.

- The HRSA Community Health and Migrant Health Center programs have received additional funds to address maternal and child health problems.

- The Department has expanded prevention, educational, and treatment efforts to reduce the demand for illicit drugs. If successful, these efforts will decrease drug related homicides among minorities.

- Proposed legislation expanding Medicaid to broaden coverage of pregnant women and children is expected to increase access and provide prenatal care for many currently underserved minorities.

Senator Kennedy

2. Q. AIDS is quickly becoming a predominantly minority disease. Two-thirds of all women with AIDS are black or Hispanic, as are over 70% of the children with AIDS. Most of the cases of AIDS among minorities have been attributed to IV drug abuse. What do you consider to be the appropriate response for DHHS to take to respond to AIDS among minority groups?

A. Clearly HIV infection and AIDS in minorities pose special challenges to the Department. To meet these challenges, the Department is undertaking a number of initiatives. To prevent the spread of HIV infection, the Department places a high priority on intravenous drug abuse (IVDA) prevention and treatment targeted to racial and ethnic populations. Our HIV prevention efforts include community-specific interventions which are tailored to the needs of individuals at risk as identified by their race, ethnicity, sex, drug use, sexual orientation, and socioeconomic status.

Other departmental programs are focused to: ensure that minorities have access to clinical trials; encourage access to appropriate health and social services in persons currently infected; and develop a data base that will permit us to target more effectively our HIV prevention strategies. To support these initiatives, a significant portion of the Department's total anticipated AIDS expenditures of over $2.5 billion in Fiscal Year 1990 will both directly and indirectly benefit minority populations.

In addition, the Third National AIDS Minority Conference is scheduled for August 14-18, 1989, in Washington. D.C. This conference will go beyond the themes of HIV/AIDS prevention and education to include other issues pertinent to this population. It is anticipated that approximately 4,000 - 5,000 people will attend the conference.

3. Senator Kennedy

QUESTION:

Over the past four years, the U.S. ranking in infant mortality has declined from 15th in the world to 17th to 19th. What do you think we should do about this sorry state of affairs?

ANSWER:

To meet the challenges facing us in infant mortality, the Department has had underway, for several years, a substantial infant mortality initiative including the Maternal and Child Health Services Block Grant, activities in the Community and Migrant Health Centers and the Indian Health Service, as well as special project grant assistance to States and communities to improve perinatal care systems. Examples of these projects -- which deal with regionalization efforts, coordination of services, and financing and outreach -- include the following:

1. A partnership between the Office of Maternal and Child Health and the Robert Wood Johnson Foundation, to assist States faced with extensive infant mortality problems in increasing access to care.

2. A $20 million comprehensive Perinatal Care Program through Community and Migrant Health Centers, to support case-managed, comprehensive care for pregnant women and infants.

3. Cooperation between the Bureau of Health Care Delivery and Assistance, the Office of Maternal and Child Health, and the National Governors' Association, to assist States with implementation of expanded Medicaid options.

4. The placement of Centers for Disease Control epidemiologists in selected State Maternal and Child Health programs to provide analytic and evaluative services.

5. A multifaceted research effort on the problem of low birthweight through the National Institute of Child Health and Human Development to study fetal development, preterm labor, and intrauterine growth retardation.

As these and other efforts continue, an interagency Low Birthweight Prevention Work Group plans to expand the perinatal capacity of Community and Migrant Health Centers; to ensure full implementation of Medicaid requirements for serving pregnant women and infants; to expand research efforts on human pregnancy and infant growth and development; and to focus attention on at-risk populations such as substance abusers, the homeless, and persons whose culture presents barriers to quality prenatal care.

In legislation soon to be transmitted to the Hill, we will propose to direct States to make Medicaid coverage available for all pregnant women and infants whose families earn up to 130 percent of the poverty level. Proposed funding would allow States to increase coverage ceilings further, providing coverage for those up to 185 percent of the poverty level. When fully implemented by the States, this initiative will serve approximately 240,000 additional women and infants (total of 2.5 million).

We will also propose Medicaid support of $20 million in grants to States with areas of high infant mortality. Participating States will coordinate these resources with funds received from the Maternal and Child Health (MCH) Block Grant and the Women, Infants, and Children (WIC) nutrition services program to address infant mortality related problems unique to each locale.

Senator Kennedy

4.

Question:

One issue about which I am extremely concerned, about which the nation is extremely concerned, is homelessness. I was pleased to note that President Bush intends to fully fund the McKinney Act--but I was dismayed to see President Reagan has proposed to terminate the Community Services Block Grant Program, which includes $42 million dollars in case management support authority for the homeless. Do you agree that homelessness is one of the most shameful problems facing out nation? Will you work with our Committee to assure that programs essential to the conduct of our national effort to reduce homelessness are maintained and expanded where necessary?

Answer:

Under President Bush's proposed budget for FY 1990, the McKinney Homeless Assistance Act would be fully funded. In all, funds in the FY 1990 budget for the homeless will total over $1 billion, including the full $42 million for case management support.

I agree with the President and you that homelessness is a serious problem facing the nation. Secretary Kemp and I will work together, whenever appropriate, and with the Congress, to reduce homelessness.

Senator Kennedy

5.

Question:

The increase in poverty over the past decade has imposed an ugly blight on this nation. The simple fact is that in the face of rising poverty among children we have seen a decrease in the rate of commitment of federal dollars to the programs to assist the poor. I am fully aware that we cannot solve problems by throwing money at them. On the other hand, those programs of proven efficacy must be expanded and improved. Among these are Headstart, Early Childhood Education of all types, "thousand points of light" programs like CSBG, child care, and health and nutrition programs for young children. What do you plan to do in these areas?

Answer:

This Administration recognizes the importance of early childhood education and health and nutrition programs for curbing the increase in poverty among our young children. We are committed to expanding and improving programs of proven efficacy, as is evidenced by President Bush's recently introduced legislative proposal to expand Head Start by $250 million in FY 1990. This would be the largest single increase in both the authorization level and appropriation level for Head Start since its inception in 1965. Up to 95,000 additional low-income four-year-olds would participate in the program in the first year of expansion, and would benefit from Head Start's comprehensive education, health, and nutrition, and social services.

In addition, we are dedicated to empowering parents, especially low-income parents, to make critical decisions about their children's care. President Bush has proposed a refundable Children's Tax Credit of up to $1,000 per child under age four in low-income working families. This, in addition to his proposal to make the current Child and Dependent Care Tax Credit refundable, wold provide additional financial assistance to very low-income families and enable them to obtain the care that best suits their needs. I am committed to working with the Treasury Department in supporting this policy proposal.

This Administration also supports programs such as the Social Services Block Grant (SSBG), which gives the states flexibility to address the social and other service needs of their communities in their own individual and innovative ways. The full authorization level of $2.7 billion for the SSBG has been requested FY 1990.

Furthermore, we support the Maternal and Child Health Block Grant (MCHBG) to assure that mothers and children, particularly those with low income or limited availability of health services, have access to quality health services. To the same end, President Bush proposes to raise mandatory medicaid eligibility for pregnant women and infants to cover ,more low-income mothers and infants. Moreover, the President's budget reflects increases in medicaid funding to accommodate recently enacted legislation.

In addition to Medicaid eligibility improvements and funding increases, the President proposes that the Federal Government lead the states in a coordinated and sustained effort to reduce infant mortality and morbidity with Infant Mortality demonstrations. Participating states wold develop coordinated programs for Medicaid, Maternal and Child Health (MCH) grants, and Women, Infant, and Children (WIC) nutrition services as the cornerstones.

Senator Kennedy

6. Q. Dr. Sullivan, the AIDS epidemic is currently the number one public health crisis facing our nation. With over 80,000 Americans already diagnosed, over half dead, and as many as 1.5 million infected, we collectively face an epidemic of staggering proportions. Please tell the Committee what your strategy will be to lead the nation's effort against AIDS. What role will you urge the President to play?

A. In the absence of a vaccine or therapy, prevention is the only effective means we have to combat the further spread of this epidemic. Education, coupled with changes in behavior, is fundamental to this effort. One component of the Department's strategy is to continue the broad-based nationwide information and education programs aimed at four major groups: the general public; health care workers; women at risk and sexually active adults with multiple partners; and parents and youths. The goals of these education efforts are to increase the knowledge of AIDS and its risk in these populations, influence their attitudes and beliefs, and ultimately change high-risk behavior. It is also important for the Department to continue ongoing educational initiatives that will encourage those individuals who are currently at low risk or no risk to maintain those behaviors that will keep them from becoming infected with the AIDS virus.

In an effort to prevent and control the HIV epidemic, I will urge the President to continue his leadership role in maintaining AIDS as a top public health priority of the Administration.

Senator Kennedy

7. Q. Consistent with the recommendations of the Institute of Medicine and other scientific authorities, the AIDS bill signed into law last year provided for an enhanced education and prevention effort, and a cost-effective and humane network of community-based care for people with AIDS. Do you support these initiatives?

A. Departmental activities already underway are expanding initiatives in these areas. We are enhancing our efforts to educate the general public, as well as directing campaigns to individuals whose behaviors increase their risk of exposure to HIV. The Department implemented another phase of its "America Responds to AIDS Campaign" which was aimed at "Women at Risk" and "Sexually Active Adults with Multiple Partners". In addition, another information and education campaign aimed at "Parents and Youths" will begin early this Summer. I will continue these multi-faceted educational efforts which, in the absence of a vaccine or therapy, are our primary means of halting the spread of infection. We also will continue to provide financial support to minority and other community-based organizations to address the need for education and prevention programs.

In addition, the Department continues to direct a number of activities related to the care of people with HIV infection and AIDS by supporting demonstration projects which supply and coordinate the multi-faceted services needed by HIV-infected individuals. Projects are being funded to support the organization of systems of care for people with HIV infection; identify unmet service needs and develop strategies to meet them; promote integration of available community resources into a system of care; promote effective case management to ensure continuity of services; and reduce the costs of medical services by developing alternatives to hospitalization.

We estimate that between 1.0 and 1.5 million individuals are infected with the AIDS virus. Eventually these individuals will become clinically ill and many will develop AIDS. In 1992 alone, the estimated costs of care for AIDS patients will be between $5 and $13 billion. Clearly, it is essential to develop and implement a long-range plan for a comprehensive system of care which is cost-effective and humane.

Senator Kennedy

8. Q. It is commonly held, and supported by recent research, that the spread of AIDS has been accelerated by many underlying social problems affecting our society, including drug addiction, homelessness and poverty. Don't you agree that a key component of our war on AIDS must be a renewed effort to solve these underlying social problems?

A. The Department will be playing a major role in the Administration's anti-drug abuse efforts. We will be collaborating with the Departments of Education, Housing and Urban Development, and Justice, and the newly established White House Office of Drug Abuse Control Policy on many drug abuse issues, including intravenous drug abuse (IVDA) and AIDS.

One-third of the AIDS cases reported in 1988 are linked in some way to intravenous drug abuse (IVDA). Although the majority of these IVDA-associated AIDS cases were reported among IVDAs, the remaining cases were among heterosexual partners of IVDAs, or children whose mothers were IVDAs or the sexual partners of IVDAs. To the extent that IVDA is an increasingly major risk factor for HIV infection, the underlying social problems associated with drug abuse (such as homelessness and poverty) play a special and terrible role in this devastating epidemic. In an effort to prevent and control the HIV epidemic, the Department will continue its major intervention strategies among IVDAs.

In addition, the Department supports research to understand better the scope and nature of the problem of homelessness and to develop appropriate mechanisms to expand housing options for the homeless. Under the McKinney Act, the PHS, through the Alcohol, Drug Abuse, and Mental Health Administration and the Health Resources and Services Administration administers grants to community-based organizations to coordinate service delivery to the homeless. Homeless and runaway teens and young adults are an especially vulnerable population because they often are involved in behaviors such as IV drug abuse and prostitution, which put them at increased risk for HIV infection. To begin to address this component of the problem, Region IX is planning a consensus conference on HIV and Runaway and Homeless Teens and Young Adults that will focus on preventing HIV infection among this population.

Senator Kennedy

9. Q. The public response to the AIDS crisis has sometimes been affected, in unfortunate ways, by public perceptions about the groups of people who have suffered most directly, and by public discomfort about sexuality. Do you agree with the Surgeon General that the government must respond compassionately to all our citizens, and that it must speak with sensitivity to the need and experiences of distinctive populations?

A. As a physician, I have taken an oath to treat the ill --whatever their personal circumstances may be. I take this oath seriously, so I wholeheartedly agree with the Surgeon General that we must respond compassionately to all our citizens and speak with sensitivity to the needs and experiences of distinctive populations.

In the absence of a vaccine or cure, information and education efforts are our only major weapon against AIDS. The epidemic already has had a major impact on our society, and it is likely to become more acute. AIDS already has taken the lives of more than 50,000 men, women, and children--many of the adults in their most productive years. Unfortunately, many Americans who are living with AIDS or HIV infection have suffered from illness and disability. Many have faced discrimination and loss of jobs, homes, or health and life insurance. Treatment of the disease is costly and will continue to add an increasing burden to our health care system.

In an effort to improve public understanding about the HIV epidemic, several years ago the Public Health Service (PHS) implemented its "America Responds to AIDS" information and education campaign. The campaign includes four major target audiences: the general public; health care workers; women at risk and sexually active adults with multiple partners; and parents and youths. In addition, the Surgeon General wrote a widely distributed Report on AIDS, and just last year, a brochure, "Understanding AIDS" was mailed to every household in the U.S.

In addition, the PHS has convened two national conferences on the prevention of HIV infection and AIDS among racial and ethnic minorities in the U.S. and will be conducting the third one here in Washington August 14-18, 1989. The PHS also has expanded existing HIV intervention programs aimed at minority populations.

Under my tenure as Secretary, I can assure you that encouraging the delivery of compassionate, effective, and comprehensive care for AIDS patients and persons infected with HIV will continue to be a high priority. The Department will continue to support the provision of health care services through the Medicare and Medicaid programs, special research projects, and demonstrations directed to developing the means to provide appropriate care to persons infected with HIV.

Individuals with AIDS who are disabled will continue to receive services through the Medicare and Medicaid programs. With respect to Medicaid, several States provide community-based care as an alternative to hospitalization for AIDS patients.

Over the past two years, the Department has been working to encourage all States to adopt anti-discrimination laws to protect all persons with HIV infection and AIDS. We currently have underway a comprehensive study of the progress States have made in this area. Also, we are enforcing actively Federal laws that prohibit any institution or private practitioner receiving Medicare, Medicaid, or other Department funds from discriminating against HIV-infected people or people with AIDS.

Senator Kennedy

10. Q. The AIDS bill established a national commission charged with making recommendations on critical policy questions concerning AIDS. However, as the Institute of Medicine has said, the existence of a commission alone does not guarantee its effectiveness. How do you plan to maximize its effectiveness, and encourage the White House to do the same?

A. On February 23, 1989, the Department submitted for consideration by the President, names of several nominees qualified for the two slots on this Commission which the President will fill by appointment.

As a member of the Commission, I will work with other Commission members appointed by the Congress and the President to assist the Administration in directing the future course that our Nation should take in combatting this devastating disease.

Senator Kennedy

11. QUESTION:

Dr. Sullivan, many of the hospitals in my home state of Massachusetts are in desperate financial trouble. In most cases, these hospitals are not inefficient, and they are not underoccupied. Instead, they are suffering from five years of Medicare payments that have not kept pace with the costs they face. My colleagues are reporting similar problems all over the country. The Reagan budget calls for more than $3 billion in Medicare cuts in payments to hospitals next year. In my judgement, reductions in that size would be disastrous for health care in Massachusetts. As someone who knows the hospital world well, what do you intend to do to see that these essential institutions are able to keep their doors open and provide the care that the American people need?

ANSWER:

I am firmly committed to ensuring that Medicare beneficiaries continue to have access to quality health care. This commitment, however, must--and, I believe can--be balanced with our need to assure the ongoing solvency of the Medicare program. Furthermore, the rising costs of Medicare continue to be the primary force driving excessive budget growth. Clearly, there is a problem, but Medicare cannot be looked at as the exclusive solution. The hospital savings we have targeted are in areas where we believe there remains unnecessary spending. For example, we believe that we no longer can afford to pay hospitals for the full cost of capital and we propose to continue limits on capital payments. This gives hospitals a strong incentive to evaluate their capital investments and make prudent financial decisions about necessary capital spending.

Senator Kennedy

12.

QUESTION:

A related problem is the failure of the Health Care Financing Administration to update the data used to adjust for differing labor costs in different areas of the country. The current adjustment is based on data that is five to seven years old. In Massachusetts we have had a booming economy that has caused wages to rise much faster than the national average--but because the data is so old, Medicare payments have not been adjusted to reflect these increases. HCFA tells us that an adjustment based on current data will be made in 1990. Can you assure this Committee that this adjustment will in fact occur?

ANSWER:

Yes. As required by statute, the Department will update the wage index by October 1, 1990 (FY 1991).

13. Senator Kennedy

QUESTION:

The average time for consideration of New Drug Applications is approximately three years and a tremendous backlog exists of new medical device applications. The call for greater resources, both dollars and staff, for the FDA is growing form Congress, industry and public interest groups. Some have suggested user fees to provide more resources for FDA. What is you view on how best to provide FDA the necessary resources to carry out is mandate?

ANSWER

This is an issue that I will have to consider in the future. I am aware that FDA's workload has steadily increased over the past decade, and FDA has taken many steps to streamline its administrative processes while still ensuring that the American consumer is protected from unsafe or ineffective products under FDA's regulatory jurisdiction.

For the present, the Administration's budget request for FY 1990 clearly contemplates providing a portion of FDA's resources ($100 million) through the collection of user fees. These fees would recover the costs of reviewing manufacturer's applications for Government approval to market new drugs, biologic, medical devices, and food additives to the public. We believe that those who derive a special financial benefit from a Government service should be charged for the costs of providing that service, rather than having it paid for by the general tax-paying public. In this case, drug and device manufacturers financially profit from obtaining Governmental approval to market their products and from the resulting enhanced public confidence in these products. This proposal is similar to the Court-approved user fees that the Federal Communications Commission and the Nuclear Regulatory Commission charge for processing licensing and tariff applications.

Furthermore, to meet rising demands, the FY 1990 budget also provides an additional $39.3 million for FDA, assuming the enactment of proposed legislation and the collection of $100 million in user fees and excluding resources for AIDS activities. This represents an 8 percent increase over the 1989 level. It includes an additional $20.8 million to cover increased operating expenses in order to maintain the current level of program services; and program increases of $14.5 million for biotechnology research and review initiatives, $3.2 million for expanded new drug and device review efforts, and $0.8 million for increased food safety surveillance activities.

Senator Kennedy

14.

Question

Many have criticized the FDA for taking an excessive amount of time to review new drugs. Yet, the FDA was able to review and approve AZT in three months. How best can we balance the need to approve drugs in a timely manner, and make a thorough assessment of safety and efficacy? Should drugs intended for "life-threatening" diseases, such as AIDS, be "fast-tracked"?

Answer

Yes. Drug intended for life-threatening diseases should be and are being "fast-tracked" by the Food and Drug Administration (FDA). As you know, the FDA has modified drug approval procedures extensively in recent years. In addition to formalizing the procedure for making investigational drugs more widely available to all those who are desperately ill, late last year, at the request of then Vice-President Bush, FDA further modified its drug approval procedures by implementing regulations to expedite the development and evaluation of drugs for AIDS and other life-threatening or severely debilitating illnesses.

The key element in these modified procedures is the need for consultation between FDA and drug sponsors early on as well as throughout the drug development process. I believe that if this is achieved, our goal of quickly bringing important therapeutic products to the American people will be realized.

Senator Kennedy

15.

Question

Up until now any new drug or medical device that can be shown to be safe and effective will be approved by the FDA, subject to the existence of a patent. Should we begin to consider both risk-benefit and cost-benefit in determinations of whether a new drug or medical device should be approved for marketing?

Answer

The FDA has traditionally looked at risk-benefit in the context of the risks to the patient of the drug or device in relation to the benefits of treating the condition for which it would be used. Cost-benefit has not been a factor in FDA's product review determinations in the past, and I believe FDA should continue its traditional role of assuring the safety and effectiveness of drug and device products without regard to cost considerations. Cost benefit has been an issue for the Health Care Financing Administration in determining which medical treatments would be eligible for reimbursement under Medicare. This entire issue is currently under study within the Department.

16. Senator Kennedy

QUESTION:

The food supply here in the United States is arguably the safest in the world. Yet, some consumer groups have argued that FDA has permitted unsafe amounts of pesticide residues on food products. Many of these pesticides are known to cause cancer. How can we best assure that no amount of any substance known to cause cancer is permitted to remain on foods? Do we need to revise the current authority relating to pesticide residues on foods, or should FDA conduct more thorough inspections?

ANSWER:

It is generally recognized that pesticides are needed to produce an economical food supply of high quality. Therefore, the pesticide regulatory system in the U.S. is designed to ensure that remaining residues do not constitute an unacceptable health risk. This system is not designed to ensure that foods will be totally free of all pesticide residues.

It is important to remember that FDA, the Environmental Protection Agency (EPA) and the U.S. Department of Agriculture (USDA) all share responsibility in the area of pesticides. EPA registers or approves the use of pesticides, and establishes tolerances, or maximum permissible residue levels that may remain on food. With the exception of meat and poultry, for which USDA is responsible, FDA is charged with enforcing these tolerances on food shipped in interstate commerce, and as part of these activities, determining the incidence and levels of pesticide residues in domestically produced and imported foods.

FDA meets its responsibility by collecting samples from individual lots of both domestically grown and imported foods and analyzing them for pesticide residues. Pesticide residues that exceed EPA's tolerances are violative; those that are at or below the tolerances are not. The methods used to analyze samples are generally capable of determining pesticide levels well below tolerance values.

Concerns are occasionally expressed about the sufficiency of FDA's sampling program. Because of the volume of products produced by the $450 billion a year food industry, FDA samples only a small fraction of the domestic and imported produce in U.S. commerce. Consequently, FDA recognizes the importance of incorporating every efficiency into its sampling program that can reasonably be made while maintaining scientifically valid results. Priority in sampling is accorded to foods of dietary

significance, high volume imports, and products with suspected or previous pesticide residue problems. In addition, primarily through reallocations, FDA has increased its resources devoted to imported food surveillance buy over 40% since 1984.

FDA's efforts to improve pesticide monitoring are currently focusing on (1) adjusting sampling strategy to include more comprehensive monitoring; (2) improving data systems to get a more complete and up-to-date picture of the results of FDA's sampling;(3) increasing the Agency's knowledge of pesticides used in the U.S. and in foreign countries so that FDA has a better idea of what residues may be on foods; and (4) improving analytical methods so that FDA can determine residues more rapidly and effectively. None of these activities require new legislation.

Significantly, data from over 25 years of FDA monitoring have shown that above-tolerance residues are rarely found, indicating that pesticide chemicals are generally used according to label directions. For example, a total of 14,492 samples of domestically produced and imported food from 79 countries were analyzed for pesticide residue in 1987. No residues were found in over 50 percent of the samples. When residues were found, they were usually at low levels and rarely exceeded tolerances. Most violative residues were found in commodities where a tolerance has not been established for a specific pesticide/commodity combination. Less than one percent of the 14,492 samples contained residues that exceeded statutory limits.

FDA's Total Diet Study, which has been conducted since the early 1960's, has continued to show that daily intakes of pesticide residues are consistently well below the acceptable daily intakes as established by the World Health Organization (WHO). The purpose of the Total Diet Study is to determine actual dietary intakes of pesticides and other chemical substances. This study constitutes the most in-depth analysis by any nation of a consumer's actual exposure to pesticides (and their degradation products) from dietary sources.

It should be remembered that EPA is the agency that must set the tolerance for pesticide residues or decide whether the tolerance should be revoked. FDA's monitoring program will show whether the residues of the sampled food items are below the EPA tolerance, as has been the case, for example, with Alar in apples. It is also worth noting that scientific advances have resulted in increasingly sophisticated analytical detection and risk assessment methodologies that enable regulatory agencies to conclude, in some circumstances, that the presence of some substances that have been shown to be carcinogens in high dose animal studies represents no real risk to human health under specified conditions of use. This was also the conclusion reached by the National Academy of Sciences in its report on pesticides. Both HHS and EPA have supported the establishment of a "negligible risk" standard for pesticides as was contained in legislation in the 100th Congress.

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SENATOR KENNEDY

17. Q. One of the serious issues facing our nation is the persistent problem of adolescent pregnancy. Do you agree that a broad range of prevention approaches is needed to address this complicated problem?:

A. Teen pregnancy is a very complicated problem and requires a broad range of approaches to deal with it. The first line of defense is the family. We know that effective family functioning, good family communication and parental supervision are factors which help teens through adolescence a little more smoothly, and these factors are correlated with lower rates of teen sexual activity and pregnancy. We must also do what we can as national leaders and as governmental program administrators to support and emphasize the importance of the family.

In terms of Federal programs, we can and do address this problem in a number of ways. The first of these is to encourage teens not to become sexually active. Sexual activity exposes teens not only to pregnancy, but also to serious and sometimes fatal sexually transmitted diseases. More than just the teen's physical health is involved. Sexual activity carries with it significant emotional consequences and confronts a teen with difficult moral and relational issues. For teens who have become sexually active, HHS funds family planning services to reduce the likelihood that they will become pregnant or become infected with a sexually transmitted disease. Finally, for teens who do become pregnant, it is important that they receive the support they need to help them through the pregnancy and complete their education, including promoting adoption as a positive option. Many local communities offer a variety of services and approaches to dealing with the crisis of teen pregnancy.

The Adolescent Family Life (AFL) Program (Title XX of the PHS Act) is the only Federal program focused exclusively on the problem of adolescent pregnancy. AFL develops and provides care services to pregnant and patenting teens. AFL also supports research on the causes and consequences of teen pregnancy and teen sexual activity. Since 1981 when AFL was created, 152 demonstration and 51 research projects have been funded. The program emphasizes dissemination of both research and demonstration project findings to date.

SENATOR KENNEDY

18. Q. When teens become pregnant, they are more likely to drop out of school, have lower rates of employment, and their babies are at higher risk of dying within the first year of life. In your view, what more could be done to decrease the adverse outcomes of adolescent pregnancy?

A. The best solution for this problem is for teens not to become pregnant, and the best way to achieve this is for teens not to become sexually active. But some teens will become pregnant, and it is important that they receive the best possible support to help them through their pregnancy. Strengthening the ability of the family to help their child through the crisis of teen pregnancy, building family support and providing guidance is crucial at such a time. It is critical that teens seek out prenatal care early in pregnancy. Too many teens wait too long before getting into a prenatal care program. Pregnant teens must be encouraged to practice healthy habits during pregnancy. Drug use, tobacco, drinking, and poor eating habits all can have terrible effects on their babies. Teens must be encouraged to stay in school or return to school after the births of their babies. About 40 percent of pregnant teens choose abortion. I would like to see more done to encourage these teens and their families to consider adoption as a positive alternative, one which can benefit them and their babies.

19. Senator Kennedy

QUESTION:

The Community and Migrant Health Center programs have been a critical component in extending access to health care to many disadvantaged Americans. Congress provided these programs with a significant increase in authorization this past year which only begins to make up for the cuts suffered over the past eight years. What do you see as the relative importance of these programs among the many programs in the Public Health Service?

ANSWER:

Community and Migrant Health Centers (C/MHCs) are extremely important because they are the Federal government's safety net for assuring access to primary health care for those the private sector does not serve. The "medical underclass" at risk for lack of primary care services includes the poor uninsured persons in areas with insufficient supplies of providers, and groups with special needs, including minority groups, high risk pregnant women and their infants, migrant and seasonal farmworkers, new immigrants to this country, the elderly, the homeless, substance abusers, and HIV-infected persons. Each of these groups need more than a financing system to assure access. C/MCHs meet those needs by building capacity where none existed-service delivery systems, providers, and now, with new legislation, facilities. Their doors are open to those refused by other providers, and they can provide the range of services needed by high risk populations, including outreach, transportation, prevention, and case management.

It is true C/MHCs face pressures from increasing demand that exceeds capacity and escalating malpractice costs, especially for obstetric services. We are confident, however, that they will be able to serve the 5.3 million patients projected for this year.

Senator Kennedy

20. In 1986, the Congress passed and the President signed into law legislation establishing a vaccine injury compensation program. An integral part of that legislation was the requirement that a plan for a National Vaccine Program be submitted annually by the Secretary of HHS. This plan was supposed to help assure that at the same time we compensated victims for vaccine injuries, we had a good program in place to prevent those injuries from occurring. This required plan has never been presented to the Congress. Can you assure this Committee that you will submit the required plan in a timely way, so that your recommendations can be considered in this year's appropriation bill.

As pointed out in the report to Congress submitted in April 1988, the intent is to take a comprehensive, future-oriented approach which is developed in consultation with the National Vaccine Advisory Committee (NVAC). The NVAC has now met four times and has been addressing components of the plan. One major underpinning of the plan has been completed - a National Vaccine Policy Statement. The 1989 report to Congress, which should be submitted within the next few weeks, will contain this policy statement. It is anticipated that the overall plan will be completed during calendar year 1989 and will be a major portion of the report to Congress in 1990.

Senator Kennedy

Q.21: According to the recent 25th Anniversary Report of the Surgeon General's Office on Smoking, tobacco use is responsible for 390,000 deaths per year, nearly one sixth of all deaths in any given year. Do you agree that this justifies making tobacco use one of the top health priorities in the nation?

A: Absolutely. Numerous reports issued by the Department of Health and Human Services, as far back as the 1979 Surgeon General's Report on Health Promotion and Disease Prevention (Healthy People), have pointed out that cigarette smoking is the single most important preventable cause of death in the United States. Cigarette smoking is one of the 15 priority areas in the 1990 Health Objectives for the Nation, and is one of 21 priority areas in the Year 2000 Health Objectives for the Nation (currently under development).

When the Department released the 1988 Surgeon General's Report, The Health Consequences of Smoking: Nicotine Addiction, former Secretary of Health and Human Services Otis R. Bowen, M.D., stated in his transmittal letter to the Congress:

"Cigarette smoking, the chief avoidable cause of premature death in this country, is responsible for more than 300,000 premature deaths each year. The disease impact of smoking justifies placing the problem of tobacco use at the top of the public health agenda. The conclusions of this report provide another compelling reason for strengthening our efforts to reduce tobacco use in our society."

Senator Kennedy

Q.22: The overwhelming majority of people who smoke begin as children. In fact, half of them begin before the 8th grade, and a quarter begin before the 6th grade. Would you agree that we must make every effort to keep our young people from taking up this deadly habit?

A: Yes. The Preface to the 1989 Surgeon General's report points out that more than 3,000 Americans begin to smoke each day, most of whom are teenagers. It emphasizes the importance of preventing the initiation of smoking because of the difficulty in quitting this addiction. The Preface states that

> "If 20 million of the 70 million children now living in the United States smoke cigarettes as adults (about 29 percent), then at least 5 million of them will die of smoking-related diseases. This figure should alarm anyone who is concerned with the future health of today's children."

The Report recommends that "Comprehensive school health education which incorporates tobacco use prevention should be provided in every school throughout the country." The Centers for Disease Control (CDC) has an active program to implement that recommendation. The March 31, 1989, issue of the CDC's Morbidity and Mortality Weekly Report reported new survey data collected by the National School Boards Association that show encouraging growth in anti-smoking education and no-smoking policies in our Nation's schools. The Department also has emphasized repeatedly the need for States to adopt and enforce laws banning the sale of tobacco products to minors.

Senator Kennedy

Q23: Though many Americans have stopped smoking since the first Surgeon General's Report, there are still 52 million Americans who do. We now know that these people are addicts. More of these people will die of their addiction to nicotine than will die from the use of dangerous narcotics like heroin and cocaine. Wouldn't you agree that we need enough treatment options for the vast majority of these people who would like to stop smoking but find that they cannot?

A: Yes. In the Preface to the Surgeon General's 1988 Report, The Health Consequences of Smoking: Nicotine Addiction, the Surgeon General recommended:

> "More effective interventions must be developed to counteract both the psychological and pharmacologic addictions that accompany tobacco use. More research is needed to evaluate how best to treat those with the strongest dependence on the drug. Treatment of tobacco addiction should be more widely available and should be considered at least as favorably by third-party payors as treatment of alcoholism and illicit drug addiction."

The National Institutes of Health, the Centers for Disease Control (CDC), and the National Institute on Drug Abuse (of the Alcohol, Drug Abuse, and Mental Health Administration) all have programs underway that are investigating the efficacy of various smoking cessation treatments as well as mechanisms to make these treatments more widely available. In addition, staff at the CDC's Office on Smoking and Health and the National Cancer Institute have initiated discussions with staff at the Health Care Financing Administration to address the possibility of reimbursement for smoking cessation treatment under the Medicare program. CDC has also provided funding for a conference later this year on insurance policies on smoking, which will address the issue of private health insurance coverage of smoking cessation treatment.

Senator Kennedy

Q.24: "Side stream" smoke also causes a significant health hazard. Would you agree that, at least in public places where the federal government has some control, innocent bystanders should be protected from the dangerous smoke from other's cigarettes?

A: Yes. The 1986 Surgeon General's Report, The Health Consequences of Involuntary Smoking, carefully reviewed the evidence that involuntary smoking (or passive smoking) is a health hazard, and came to three major conclusions: (1) Involuntary smoking is a cause of disease, including lung cancer, in healthy nonsmokers; (2) The children of parents who smoke, compared with the children of nonsmoking parents, have an increased frequency of respiratory infections such as pneumonia and bronchitis; and (3) Simple separation of smokers and nonsmokers within the same air space may reduce, but does not eliminate, exposure of nonsmokers to environmental tobacco smoke.

In his letter transmitting this report to Congress, former Secretary of Health and Human Services Otis R. Bowen, M.D., stated that "Based on the evidence presented in this report, the choice to smoke should not interfere with the nonsmoker's choice for an environment free of tobacco smoke." Since release of that report, the Department has established a smoke-free environment for all its facilities, affecting about 120,000 DHHS employees nationwide. In addition, the Office of Disease Prevention and Health Promotion and the Centers for Disease Control's Office on Smoking and Health produced a booklet designed to help employers establish a no-smoking environment in the workplace (A Decision Maker's Guide to Reducing Smoking at the Worksite).

Senator Kennedy

25. Dr. Sullivan, would you agree that a strong biomedical research effort is vital to our nation's ability to provide quality medical care and public health services?

Answer

To a large extent the advances in biomedical research today determine medical practice available tomorrow. From the results of research come the means of improving the quality of health care and, ultimately, of reducing its costs.

In this unprecedented era of discoveries in molecular biology, genetics, immunology, and neurobiology, scientists are coming closer than ever before in the history of medicine to understanding the basic mechanisms of living processes in cells and tissues, and there is a high degree of confidence that the underlying mechanisms of disease are becoming approachable because of these insights.

We are entering a very exciting era for clinical research as well. The pace of scientific discovery has accelerated greatly and the time elapsed between the development of new knowledge and its medical application has begun to diminish. Two examples from the plethora available from the research frontiers can be noted:

- In 1973, just 20 years after the resolution of the structure of DNA by Drs. Watson and Crick, the first successful recombinant DNA experiment was performed. In 1978, only five years later, the first recombinant human insulin was created. In 1982, Humulin was marketed, and today many other recombinant products are being applied to treat human disease.

- A striking example of the continued reduction in the time between the realization of fundamental biomedical understandings and their dissemination into practice is offered by the AIDS crisis. In 1981 the disease was recognized, in 1984 the causative virus was identified and in 1986 clinical studies of AZT were initiated.

Clearly, a vital link does exist between a strong biomedical research effort and the nation's ability to provide quality medical care and public health services.

26. Senator Kennedy

QUESTION:

Last year the Senate passed a bill that would have assisted our nation's research institutions to build more research space. From your experience in running a medical school, what do you think of this proposal?

ANSWER:

The Department has been requested by the House Appropriations Subcommittee on Labor/HHS/Education to provide information on the state of the nation's health research facilities infrastructure, the relative need for new approaches to upgrading or expanding those facilities and an analysis of the pros and cons of a variety of funding approaches. A symposium sponsored by the Department will be held at the National Academy of Sciences on April 25, 1989, to provide us with a wide ranging set of view on the many issues which have arisen in connection with facilities development. The Department's report on this subject, to be submitted during May 1989, will include discussion of the relative need for Federal assistance; financial strategies, including the most appropriate mix of Federal and non-Federal funding sources; and direct and indirect cost mechanisms as appropriate mechanisms for financing facilities. Since the Department is currently in the process of considering alternative solutions to this issue, it would be premature to comment at this time on specific proposals.

Senator Kennedy

27. Dr. Sullivan, I am sure you are aware of the attention which has been focused on the issue of scientific misconduct over the last couple of years. Would you agree that it is important for the Department to promote the highest integrity in scientific research and to establish clear and strong standards for academic institutions to follow in handling these problems when they do occur?

As the steward of the vast majority of available Federal awards for biomedical and behavioral research, the DHHS will continue to ensure that it has an effective process in place for dealing with misconduct and for promoting high integrity in research.

In July 1986, the NIH guide to Grants and Contracts published the PHS Interim Policies and Procedures for Dealing with Possible Misconduct in Science which spelled out the principles which have guided the PHS agencies' implementation of the Health Research Authorization Act of 1985 (P.L. 99-158). In September 1988, DHHS published a notice of proposed rulemaking requiring assurances that PHS applicant and awardee institutions have established administrative processes for investigating and reporting allegations of misconduct in scientific research and proposing criteria for compliance with such assurances. Based on our experience with the interim guidelines and the public comment, the final rule has been developed and is currently under review at the Office of Management and Budget.

Over the last year, the Office of the Assistant Secretary for Health, NIH, and ADAMHA have consulted with the research community on how to improve our own system for dealing with scientific misconduct. As a result, the PHS decided that the establishment of two offices--complementary but not overlapping--would strengthen its oversight and investigative functions in detecting and preventing scientific misconduct. Any allegations or suspicions of misconduct in biomedical or behavioral research, research training, and related activities supported with funds authorized by the PHS Act will be handled by these offices.

The Office of Scientific Integrity (OSI) will be housed in the Office of the Director, NIH, and jointly administered by NIH and ADAMHA. The OSI will see that all PHS policies and procedures related to scientific misconduct are implemented; will monitor the individual investigations into scientific misconduct conducted by institutions that receive PHS funds; and, as necessary, will conduct its own investigations.

The Office of Scientific Integrity Review (OSIR), in the Office of the Assistant Secretary for Health, will establish overall PHS policies and procedures for dealing with misconduct in science. will review all final reports of investigations to ensure that any findings and recommendations are sufficiently documented; and will make final recommendations to the Assistant Secretary for Health on whether any sanctions should be imposed by DHHS, and if so, what they should be.

Senator Kennedy

28. The Committee on Science, Engineering, and Public Policy of the National Academy of Sciences is planning a comprehensive look at the problem of scientific misconduct and how to handle such problems. Would you commit the Department to cooperation with the Academy of Sciences in this effort?

In September 1987, the NIH established a contract with the Institute of Medicine (IOM) to develop the report on "The Responsible Conduct of Research in the Health Sciences, released in February 1989. The PHS concurs with the report's recommendation to strengthen and enhance the PHS and research institutions interactions in developing workable policies and procedures for detecting and preventing misconduct and for promoting integrity in biomedical and behavioral research.

The Department will look carefully at the plans of the Committee on Science, Engineering, and Public Policy for an extension of the IOM study to the physical sciences and engineering. We have not yet had the opportunity to study the final proposal. Hence, it would not be appropriate for me to make such a commitment at this time.

29. Senator Kennedy

QUESTION:

Many graduate and professional students borrow heavily to finance their education. According to the Association of American Medical Colleges, the average medical student borrower graduates with almost $40,000 in educational debts. I am concerned that the prospect of repaying loans discourages some students from going to medical school and influences their personal and professional choices. I will shortly introduce legislation that would require a study of this issue by the National Advisory Committee on Student Financial Assistance.

Do you believe that medical students are borrowing excessive amount of money to finance their education? Will you work closely with this Committee in gathering evidence to analyze this issue? Do you believe that we should revise the existing student aid programs to address this problem?

ANSWER:

Data show that in 1987 the average debt for minority medical school graduated was $41,457, compared to $35,104 for nonminority graduates. The amount of both minority and nonminority debt would not appear to be an insurmountable barrier to pursuing the practice of medicine, given a physician's expected lifetime earnings. It may influence against the choice of primary care specialties, however, with lower rates of return on educational investment.

We are aware of this issue and will continue to monitor the efforts of the Association of American Medical Colleges and other organizations as they investigate the borrowing of medical students.

Currently, there are no plans to revise the existing health professions student aid programs to address the issue. The Health Professions Student Loan Program, administered through the schools, provides for low-costs loan assistance to exceptionally needy medical students. In addition, the Health Education Assistance Loan (HEAL) program provides for Federal insurance of market-rate loans from non-Federal lenders to medical students in financial need.

Senator Kennedy

30.

Question:

Last year the Office of Human Development Services within the Department of Health and Human Services proposed a reorganization of the Administration on Children, Youth and Families on both the national and regional levels. Do you plan to continue this proposed reorganization? If so, will this reorganization have any programmatic effects? What efforts are being made to ensure proper training of personnel who will be taken on new responsibilities?

Answer:

The proposal to reorganize Administration on Children, Youth and Families (ACYF) by the previous Administration is currently under review, and the decision as to whether to proceed with this proposal or not has not yet been made.

The proposed reorganization at the regional level also is being reviewed currently within the Department. Please be assured that President Bush's Administration shares your concerns about young persons, their families, and the programs that serve them. Our common goal is to provide the most effective and efficient programs possible for children and families.

31.

Question:

President Bush said during the campaign that he wanted to increase funding for Head Start in order to serve all eligible 4-year-olds. What is the timetable for achieving that goal?

Answer:

Working towards the goal of serving all eligible four year olds, President Bush has requested an increase of $250 million for the Head Start program for FY 1990. If appropriated, this increase will enable Head Start to provide services up to 95,000 additional low-income four year olds.

32.

Senator Kennedy

QUESTION:

Occupational safety and health hazards are a major concern for the nation's workers. More than 100,000 are killed each year from traumatic injuries and as many as 100,000 die from chronic occupation diseases. The resources devoted to research and investigations on these problems are relatively small. The National Institute for Occupational Safety and Health (NIOSH) has a budget of $70,355 million which President Bush proposes to reduce to $44,586 million in FY 1990. If these cuts are implemented, what programs, activities and research projects will be reduced or eliminated?

ANSWER:

If the NIOSH FY 1990 budget request is implemented, the NIOSH research budget will be decreased by $19 million (31 percent) and the NIOSH training budget will be decreased by $6 million (67 percent).

We would include for the record a funding table contained in the Fiscal Year 1990 Congressional Budget Justifications which displays, in more detail, how these funding reductions are planned to be allocated.

Occupational Safety and Health
Funding by Activity

81

Intramural Research	FY 88 Actual	FY 89 Estimate	FY 90 Estimate
Identification:			
Surveillance	$ 6,900,000	$ 6,900,000	$ 6,200,000
Health Hazard Evaluation/Technical Assistance	8,600,000	8,600,000	8,286,000
Targeted Research:			
Occupational Lung Diseases	6,425,000	6,523,000	5,900,000
Musculoskeletal Injuries	1,300,000	1,300,000	1,000,000
Occupational Cancers	3,638,000	3,650,000	3,100,000
Severe Occupational Traumatic Injuries	735,000	735,000	400,000
Occupationally Related Cardiovascular Diseases	330,000	330,000	200,000
Disorders of Reproduction	1,850,000	1,850,000	1,200,000
Neurotoxic Disorders	885,000	885,000	500,000
Noise-Induced Loss of Hearing	385,000	385,000	200,000
Dermatologic Conditions	315,000	315,000	200,000
Psychologic Disorders	675,000	675,000	400,000
Control and Personal Protective Equipment	7,985,000	7,985,000	6,500,000
Dissemination	6,727,000	6,927,000	6,000,000
Subtotal	$46,750,000	$47,060,000	$ 40,086,000

Extramural Research:	FY 88 Actual	FY 89 Estimate	FY 90 Estimate
Identification:			
Surveillance	$ 1,400,000	$ 1,400,000	$
Health Hazard Evaluation/Technical Assistance	300,000	300,000	200,000
Targeted Research:			
Occupational Lung Diseases	2,310,000	2,310,000	150,000
Musculoskeletal Injuries	640,000	640,000	50,000
Occupational Cancers	725,000	725,000	100,000
Severe Occupational Traumatic Injuries	350,000	350,000	50,000
Occupationally Related Cardiovascular Diseases	310,000	310,000	50,000
Disorders of Reproduction	950,000	950,000	50,000
Neurotoxic Disorders	930,000	930,000	50,000
Noise-Induced Loss of Hearing	625,000	625,000	50,000
Dermatologic Conditions	375,000	375,000	25,000
Psychologic Disorders	685,000	685,000	25,000
Control and Personal Protective Equipment	2,100,000	2,100,000	
Dissemination	1,500,000	1,500,000	400,000
Subtotal	$ 13,200,000/1	$13,200,000/2	$1,200,000
Training	9,718,000	10,095,000	3,300,000
Total, Occupational Safety & Health	$ 69,668,000	$70,355,000	$44,586,000

/1 Includes $6,224,000 in research grants
/2 Includes $6,149,000 in research grants

SENATOR KENNEDY

33. Q. In addition to NIOSH what are the programs and resources devoted to occupational safety and health research, training and investigation that are expended by other PHS agencies including CDC, NCI, and each of the other NIH Institutes? Are there any plans for increasing the activities or resources devoted to occupational safety and health research, training or investigations by each of these agencies?

A. The National Institute of Environmental Health Sciences (NIEHS) is conducting two epidemiologic studies. One is of meat packers who are exposed to animal viruses and plastic wrapping fumes, and the other is looking for adverse health effects in pesticide applicators in Australia who were exposed to very high levels of the contaminant dioxin.

In addition, the NIEHS manages two grant programs which are supported by the Environmental Protection Agency Superfund. The first provides training to workers and their supervisors responsible fore environmental cleanup, routine disposal of hazardous waste, and hazardous substances emergency response. This program is funded at $10 million per year and supports eleven training grants. The second provides approximately $1 million for training in occupational and environmental medicine through nine universities.

NCI has a broad range of studies underway to identify and clarify the role of workplace exposures in the origin of cancer. These studies span a number of industries and focus on a variety of potentially hazardous agents. Estimated funding for these studies is $15.5 million for FY 1989 and $15.9 million for FY 1990.

Finally, through CDC's Center for Environmental Health and Injury Control, there are approximately five extramural grants totalling $900,000 that directly or indirectly address occupational injury surveillance and injury prevention in such worksites as small to medium size businesses, farms, and the trucking industry. These have been coordinated with the activities of the National Institute for Occupational Safety and Health.

Senator Harkin

1.

Question

In 1987, Congress recommended that the Department of Health and Human Services establish a interagency head injury task force to identify the gaps in research, training and service delivery and to recommend solutions in addressing the needs of persons with traumatic head injuries. Secretary Bowen established this task force in late 1987 with the National Institute of Neurological Disorders and Stroke serving as the lead agency. After holding meetings and public hearings in 1988, the task force has now presented its final recommendations to Secretary Bowen.

Will you support the Task Force's recommendations and what efforts will you make to see that the recommendations are implemented?

Answer

The Interagency Head Injury Task Force Report has been submitted to the Acting Assistant Secretary for Health for review. I look forward to receiving it soon and to becoming familiar with the recommendations and issues presented.

Senator Matsunaga

1.

Question:

Dr. Sullivan, the 1987 Amendments to the Older Americans Act elevated the status of the Commissioner on Aging, directing the Commissioner to report directly to the Secretary of Health and Human Services and giving the Commissioner significant new managerial authority within the Administration on Aging. The Report of this Committee on the Older Americans Act Amendments of 1987 stated that the Commissioner on Aging "is to have independent access to the Secretary, and to function with the same level of authority as Assistant Secretaries and other commissioners within the Department." It is my understanding that this change has not yet been implemented by the Department of Health and Human Services. As Secretary, would you attempt to expedite this matter?

Answer:

The Department of Health and Human Services has taken the necessary steps to carry out all provisions of the Older Americans Act Amendments of 1987, including section 102 which establishes a direct reporting relationship between the Commissioner on Aging and the Secretary of Health and Human Services:

- On January 28, 1988, the Secretary of Health and Human Services issued a memorandum to all operating and staff divisions directing the Commissioner on Aging to report directly to the Secretary to ensure that concerns of Older Americans are considered fully in various policy matters addressed by the Department.

- In the same memorandum, the Secretary directed the Assistant Secretary for Management and Budget to examine the organizational and support matters concerning the AoA raised by the recent amendments, and that, pending completion of the Assistant Secretary's study, AoA continue to receive logistic and other support through existing arrangements. The Assistant Secretary for Management and Budget has procured a contract with Macro Systems, Inc., to examine these matters. We anticipate completion of the study in the very near future.

- Several steps have been taken to assure the Commissioner on Aging greater autonomy within the existing arrangements of support services for AoA while the study is being completed:

  -- Final Rules for Grants to State and Community Programs on Aging and Grants to Indian Tribes and Organizations Serving Older Native Hawaiians for Supportive and

Nutrition Services were announced in the Federal Register on August 31, 1988, under the signature of the Commissioner on Aging and the Secretary of HHS.

-- The Assistant Secretary for Human Development Services and the Commissioner on Aging agreed that AoA no longer would participate in HDS' Coordinated Discretionary Program. This means that the Commissioner has independent decision-making authority over AoA's research and demonstration activities.

-- On May 2, 1988, the Assistant Secretary for Human Development Services provided the Commissioner on Aging control over salaries and expenses allocated for AoA activities supported through the Program Administration portion of the HDS appropriation.

In the near future, I will be reviewing the organizational status of the AoA, along with other pending organizational issues. The needs and concerns of older individuals are a priority of mine, and will weigh heavily in all deliberations and decisions regarding the AoA.

Senator Matsunaga

2.

Question:

In an effort to address tne special needs of older Native Americans, Congress also directed that an office for American Indian, Alaskan Native and Native Hawaiian Programs be established within the Administration on Aging, and that an Associate Commissioner be appointed to head it. To date, this change has not been implemented. As Secretary of Health and Human Services, would you attempt to expedite the appointment of an Associate Commissioner of Aging for American Indian, Alaskan Native and Native Hawaiian Programs?

Answer:

The Department of Health and Human Services is taking the necessary steps to carry out all provisions of Public Law 100-175, including section 107(b), which establishes an Office of American Indian, Alaskan Native and Native Hawaiian Programs headed by an Associate Commissioner within AoA. A plan to create this office and position within AoA is currently under review within the appropriate staff offices in the Department. The process to establish organizationally an office and position with the level of responsibility and stature as the Office of American Indian, Alaskan Native and Native Hawaiian Programs should have is complex, and often the time frame for completion exceeds our desires. I will be reviewing this issue, along with other Departmental organizational issues, in the near future.

Senator Mikulski

1. QUESTION:

As you may know, I am very concerned about the quality of clinical laboratories in this country. I sponsored legislation last year which is now law to assure the American people that they could place greater reliance in the future upon the results of clinical lab tests. I have a few questions for you related to this law:

What is the status of the regulation related to this law? Do you believe that you have sufficient personnel to adequately enforce this law?

With regard to the certificate of exemption for laboratories performing simple tests, I am concerned that HCFA not draft this exemption so broadly that we render the regulations worthless because so many laboratories are exempt. Can you tell me what you are doing to ensure that all views on what constitutes a "simple" test are being represented, and that this exemption not be crafted in such a way that too many laboratories, including physician office laboratories, are waived?

ANSWER:

We proposed to reform the Medicare regulation of laboratories in a notice of proposed rulemaking published on August 5, 1988, prior to the enactment of the Clinical Laboratory Improvement Act of 1988 (CLIA). The regulations address many of the quality improvements enacted in CLIA including, for example, national uniform proficiency testing. Our intention is to issue these regulations in final form by the end of the year. These regulations will be consistent with CLIA and implement major portions of the law. For those parts of CLIA that are not encompassed by these regulations, our intention is to publish a separate Notice of Proposed Rulemaking.

We believe we have adequate personnel to develop and implement regulations prescribing laboratory standards and regulations governing enforcement of these standards. Nevertheless, we are evaluating currently the impact of CLIA on Federal and State agency personnel who will be conducting the actual inspections and providing the necessary Federal oversight. This evaluation must take into account other enforcement mandates, particularly for nursing homes as required under OBRA 1987. The potential impact of private sector involvement through national accrediting bodies provided for under CLIA also must be assessed.

We currently do not believe a large number of laboratories will be exempted from CLIA requirements. We believe this is consistent with Congressional intent to improve and strengthen the overall quality of laboratory performance. We are seeking

the advice of experts to develop the exemption criteria for simple, low risk tests. Some of the major organizations are: the American Medical Association, the College of American Pathologists, the American Academy of Allergy and Immunology, the Health Industry Manufacturers Association, the Joint Commission of Accreditation of Healthcare Organizations, and the American Association of Bioanalysts.

SENATOR MIKULSKI

2. Dr. Sullivan, one of the strong beliefs I have is that the government should be the leading example for the nation's work force. I depend on the leaders of the executive branch to provide this leadership. Often they receive my encouragement, although criticism is sometimes necessary, on their initiatives regarding changes in the workplace.

I am sure that you are aware that there are many federal employees in my state of Maryland that are part of the Department of Health and Human Services. Last year it came to my attention that many civil servants in clerical positions working the Baltimore region believed that there were recruitment, retention and morale problems. As such, the Appropriations Committee, of which I am also a member, included in the report accompanying the Treasury, Postal Service, and General Government Appropriations bill, 1989, language requesting HHS to coordinate among specific sister agencies "a new staffing survey of clerical positions to determine whether recruitment, retention and morale problems exist that warrant submission of a special rate request to the Office of Personnel Management."

In the report that your agency supplies to the Appropriations Committee regarding the status of such requests, this study is not even listed. Dr. Sullivan, would you please tell me when you expect to submit this study to the Appropriations Committee and why there was this lapse in keeping the Committee apprised of its status.

Like the Senator, I firmly believe that the federal government must set examples for the nation to follow by implementing initiatives regarding changes in the workforce. I have already begun by implementing a number of changes that will improve the quality of the workplace for employees of the Department of Health and Human Services, and hope that others within and outside the federal establishment will follow my examples.

This Department now pays special salary rates to assist in recruitment and retention of more than 12,000 employees, mostly in clerical positions, many in your state of Maryland. I will continue to support all valid requests for payment of special salary rates to employees of this Department whenever the indicators required by the Office of Personnel Management to approve such requests are present.

Page 2 - Senator Mikulski (Question 2)

This Department was not aware of the Appropriations Committee's request for conducting a study of clerical staffing for the Baltimore area until this past month when called by a member of the Senator's staff. It is not our usual practice to examine appropriations reports from subcommittees with which the Department has no ongoing working relationship, and notice of this requirement was never forwarded to the Department for information or action.

It is interesting to note, however, that in November 1988 the Deputy Director of the Office of Personnel Management ordered the Baltimore Federal Executive Board to convene a special task force to study special salary needs of the Baltimore area clerical work force. This Department actively participated in the study with two members on the task force, representing the Social Security Administration and the Health Care Financing Administration. Both agencies have significant numbers of clerical personnel stationed in the Baltimore area.

I have been advised that the task force conducted an exhaustive study of recruitment and retention of clerical employees for all federal agencies in the Baltimore area, including the collection of data required by the Office of Personnel Management when submitting special salary rate requests. I am told that the study is now completed and that one or more requests for approval of special salary rates will be forwarded to the Office of Personnel Management in the near future.

I regret that this Department was not made aware of your interest in conducting a review of clerical staffing in the Baltimore area in time to meet the reporting deadline contained in the committee report. However, since the study conducted by the Baltimore Federal Executive Board has fulfilled the Committee's request you cited, I believe that their efforts should not be duplicated by conducting a second study. I assure you that I will carefully consider the recommendations of the Baltimore Federal Executive Board.

Senator Mikulski

3.

Question:

In light of the tremendous problem we have in this country with abuse among families, are you committed to increasing the funding for the Family Violence Prevention and Services Act?

What other ways would you propose for the Federal government to raise the level of awareness about family violence, particularly since there is such strong connection between family violence and child abuse?

Answer:

Under the Bush Administration budget proposals, the funding for the Family Violence Prevention and Services Act is contained in the residual freeze category, which includes numerous programs across the government. For all these programs, in aggregate, 1990 outlays would not exceed total outlays for such programs in 1989. This does not mean that each Federal program within this category must be frozen. The freeze is flexible in that it allows for negotiations between Congress and the Administration to determine appropriate funding priorities.

As budget negotiations between the Administration and the Congress move forward, we are treating the Reagan budget proposals as Bush Administration proposals. The Administration requested $8,219,000 to fund the Family Violence Prevention and Services Act for FY 1990, the same amount as the FY 1989 Congressional appropriation for activities under the Act.

The activities currently supported under the Act recognize the connection between family violence and child abuse and work to raise the level of awareness about family violence. For example several States and Indian Tribes have sponsored public education/public awareness activities with schools and local community organizations as part of their family violence grant programs.

Other activities supported by the Act included training of law enforcement personnel by the Department of Justice; establishing the National Clearinghouse on Family Violence Prevention; and research, coordination and technical assistance activities.

Senator Simon

1.

QUESTION: In Illinois, I have heard several complaints from the Area Agencies concerning the appropriate role of the Commissioner on Aging. There is concern among senior citizen organizations of the Commissioner's alleged definition of her position as primarily serving the State Units on Aging.

Reading the Older Americans Act identifies a Commissioner on Aging with responsibility for all older persons and the programs, services and research necessary to improve the quality of life.

What is your impressions on the Aging Network and the role of the Commissioner on Aging in providing national leadership?

ANSWER: I am fully committed to all of the duties and functions of the Commissioner on Aging which are set forth in section 202 of the Older Americans Act, as amended. Included among those duties and functions is the responsibility to serve at the national level as the effective and visible advocate for the elderly within the Department of Health and Human Services and with other departments, agencies and instrumentalities of the Federal government. In addition, as required by section 202, the Commissioner on Aging must provide leadership to the field of aging at all levels through establishing national policy directions, providing various forms of assistance, and fostering coordination and partnerships among all those engaged in serving our Nation's older people. The Older Americans Act assigns to State Agencies on Aging statewide leadership and oversight responsibilities for the operation of programs for older persons within their respective States. In carrying out these responsibilities, State Agencies on Aging must foster effective partnerships with other State level agencies, with service providers, and with the older persons themselves, and their representatives and provide oversight and direction to their Area Agencies on Aging.

Senator Simon

2.

Question:

The American Bar Association's section of Administrative Law and Regulatory Practice has recently approved two resolutions pertaining to the Department of Health and Human Services. The first suggests that DHHS and HCFA adopt more detailed and comprehensive procedures consistent with generally accepted principles of due process. The second requests that HHS implement the Freedom of Information Act by providing by providing public access to texts of certain administrative appeals decisions. As Secretary of HHS, what are your responses to these proposals?

Answer:

With respect to the first part of the question, the Department has well-established procedures to assure that due process is provided appropriately. These procedures are both administratively established and set in statute, and are implemented through regulations published in the Federal Register. We appreciate the desire for consistent procedures and attempt, whenever possible, to develop a uniform process for similar classes of actions. Of course, our primary concern is to establish an appeals process that is equitable, and we believe that the current system meets that test.

Publication of all HCFA interpretive guidelines in the Federal Register would not be appropriate. The Secretary does publish all rules, requirements, or policy statements that establish or change substantive legal standards or regulatory policy. The Secretary also publishes quarterly in the Federal Register a list of all Medicare program manual instructions, interpretive rules,policy statements, and guidelines. The actual documents may be reviewed at approximately 1,400 local libraries throughout the country which participate in the Federal Depository Library Program. These materials are also available to the public for a fee through the National Technical Information Systems and the Government Printing Office. Interpretive materials, guidelines, and policies relating to Medicare payments are also available through the Medicare fiscal intermediaries and carriers.

With regard to the second part of the question dealing with the FOI resolution, pursuant to 5 U.S.C. 552(a)(2), the Department makes available to the public final opinions, indexes, transcripts, or pleadings filed in agency litigation. We are not aware of the need for any additional regulations in this area. In accordance with 42 CFR 401.118, identifying information may be deleted from opinion, orders, or other records relating to private parties when such records are made available to the public. The Department has no plans to amend these

regulations.

The Department is continually updating its rules of procedure for various classes of administrative proceedings, and where necessary or appropriate, those rules will be made more comprehensive. For example, we are studying the regulations governing determinations that affect participation in Medicare and Medicaid programs, and consideration is being given to substantially broadening those regulations to establish rules to resolve procedural questions that frequently arise in that context. However, given the broad range of administrative procedures for which this agency is responsible and the substantial variation that exists among these programs in terms of complexity, statutory requirements, nature of the parties, and interests of the public,it does not appear at this time that generally applicable procedural regulations would be practicable.

Senator Simon

3.

Question:

During this Congress, the Head Start program will need to be reauthorized. Study after study has proven the effectiveness of the Head Start Program yet this program is serving less than 40% of those children who are eligible.

What is the role of the federal government in expanding early childhood education opportunities? What types of programs do you do you believe we should be looking at to complement Head Start? How do we continue to provide the support services and parental involvement that have made Head Start so successful while increasing the role of the education community in providing early childhood education?

Answer:

The role of the Federal Government in expanding early childhood opportunities should be twofold. The first is working to increase the number of children and families we are able to serve through the Head Start program. President Bush has taken a major step forward in this regard by requesting a FY 1990 increase for Head Start of $250 million. The second is one of advocacy, training and assisting interested states and localities in establishing Head Start or Head-Start-like programs to serve 4-year-olds.

There is growing awareness in a many States of the importance of early childhood development. Some 28 States have established such programs and new legislation is being considered in other States. Head Start continues to serve as a model in the design of these new programs; in at least eight cases, States are supplementing the funding of Head Start programs to enable more children to be served. Therefore, in addition to increasing direct support of Head Start child development services, we will be working more closely with local and State governments to provide whatever information we can and to ensure that the delivery of State and Federal services are coordinated. We hope to encourage the adoption of some of the important lessons learned through Head Start: that parental involvement is a critical element in all programs and that services for low-income children should be comprehensive and include health, nutrition, and social services.

SENATOR SIMON

4. Q. The Federal family planning programs, both domestic and international, have suffered in recent years. This year, the Congress once again will try and reauthorize Title X, the Federal family planning program administered by HHS.

What are your views on family planning? On sex education in the schools? Do you believe that the restictions curently in the Federal family planning law are strong enough to prevent any Federal money from being used to support abortion related services?

Understanding the realities of today's youth, what types of programs are you ready to recommend to address the problems of teenage pregnancy?

A. Family planning is an important component of the health care system. I know family planning programs can be controversial, and the best way to keep controversy under control and allow these programs to do their job is to make certain that the program does not become entangled with abortion and that the activities supported by the program are reflective of local concerns and community standards.

Sex education in the schools is a very sensitive issue because opinions differ about what is proper for inclusion in such programs and to what extent they are a proper function of the educational system at all. I believe that the Federal government should stay clear of mandating sex education in schools or dictating the content of sex education. Decisions about whether to sponsor sex education and what to include is a question best left to local communities, and those communities are best advised to work closely with parents in determining how best to address this issue. After all, research suggests that sex education programs have not been effective in reducing teen pregnancy. We must tread cautiously before we recommend approaches that may not be effective.

I believe that the abortion prohibition in Title X is a sufficient statutory base, but I think that the regulations issued February 2, 1988, are necessary to clarify the implementation of this statutory prohibition.

On the issue of teen pregnancy, the first line of defense is our families; there is no real substitute for the love and nurturing that a family can provide. We know that well-functioning families, good family communication and parental supervision are key factors in helping teens decide not to become sexually active. It is crucial that local

communities be involved in dealing with the problem of teen pregnancy, as well as other problems of young people such as drinking, using drugs and dropping out of school.

Additionally, HHS supports a variety of programs which work to encourage teens not to become sexually active, programs which provide family planning services to sexually active teens, and a variety of different programs which provide health, educational, and social services, including adoption services, to those who become pregnant.

The Administration has proposed continuation of the Adolescent Family Life (AFL) demonstration and research program, the only Federal program focused exclusively on preventing teen sexual activity and assisting pregnant and parenting teens, at current funding levels ($9.5 Million) for 3 years. The AFL program encourages family involvement and promotes as an option for pregnant teens.

5. Senator Simon

QUESTION:

Last year, Secretary Bowen met at my request with Kathleen Mulligan of Methuen, Massachusetts on the issue of the income cap on SSI for families raising their disabled children at home. Since that meeting, Mrs. Mulligan and other have been seeking to clarify the Department of Health and Human Services' interpretation of the regulatory language in USC 1382c (f)(2). This regulation appears to give the Secretary of HHS the authority, when individual circumstances make the income of a child under 18 is deemed to include any income and resources of a parent who is living in the same household.

Ms. Mulligan argues that this authority was even pointed out by President Reagan early in his term in regard to an individual child (the Katy Beckett case). The present situation causes people to misrepresent the facts about whether the father lives in the home. It further contributes to decisions to leave children in institutions.

I was very disappointed to receive a December 8, 1988, response from the former Secretary indicating that HHS has no intent to permit individual decisions in this area. I respectfully ask that you carefully consider the merits of this policy and that you submit a clear and independent interpretation of the Secretary's authority under this section.

ANSWER:

The delivery of an adequate system of health care for severely disabled children is a goal we both wish to achieve. Families with children who have benefited from recent changes in medical technology, such as the Mulligans of Massachusetts, have extraordinary and compelling health-related needs. The solution that you propose to address their unmet health costs would require a change in the SSI program so that the parents' income is not a factor in determining the SSI eligibility of the children. Such a change would alter the fundamental purpose of the SSI program, a program designed and funded to provide for the most basic of needs: food, clothing, and shelter for those most economically disadvantaged.

Currently, my Department is conducting an exploratory study to synthesize existing data on the health and related care needs of severely disabled children. Some of the areas we plan to address are the service needs of these children and what is the role of the public and private sectors in meeting those needs.

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1. Senator Hatch

QUESTION:

The HHS Department has many outside advisory committees. I am not aware of any single such committee that directs its attention to advising the Department on matters concerning the field of self-care and self-medication. I understand self-care is the largest single segment of health care. It would seem wise to have at least one committee to advise the Department (or FDA) in this field. Would you consider appointing such a committee?

ANSWER:

I am aware that the Proprietary Association has suggested that a new advisory committee devoted to OTC issues be created. The possibility of an advisory committee on self-care/self-medication is certainly something I would seriously review to see if it would be beneficial to the Department.

2. Senator Hatch

QUESTION:

I noticed in a January 1989 Heritage Foundation Report a recommendation that more prescription drugs with proven records of safety and effectiveness should be sold over-the-counter. This way, consumers would have the opportunity to use those products without having to go to a doctor, and consequently, save money. In fact, according to the Department of Commerce's 1989 Industrial Outlook, "the self-care trend is reducing overall health care costs as more and more products become available." The report said, "These OTC drugs save the public an estimated $24 billion a year in doctor's bills and time lost from work."

It seems to me that with the proven interest of American consumers in taking more control over their own health including things like attention to diet and exercise, making prescription products available over-the-counter is a good way of serving the consumer. I understand in some ways, we have a "OTC drug lag." Other developed countries permit products such as 1 percent hydrocortisone to be sold over-the counter. But, in America it is only available over-the-counter at half the strength. In fact, Denmark just recently switched 81 drug products from prescription to over-the-counter -- many of which are not available in the United States.

Do you think more attention could be given to this area, both as a cost-saving measure and to serve the public's interest in health care?

ANSWER:

I am not aware of a so called OTC "drug lag." I have been informed that FDA is continuing the enormous task of the OTC drug review and is committed to exploring a number of new means to enhance the consumer use of OTC medicines.

3.

Senator Hatch

QUESTION:

A recent Gallup poll shows that 75 percent of Americans today read medicine labels more carefully; 72 percent are more careful about the medicines they take; and 40 percent are more likely to use an OTC. I believe this reflects a growing recognition of the importance of self care/self medication.

I wonder whether we are devoting enough resources to the field of self-care medication. Canada has an entire government bureau devoted to OTCs, and they could be considered ahead of us in that regard. I've heard predictions that the field of self-medication will, if given appropriate attention, grow dramatically in the coming years. The Commerce Department estimates that the OTC market will be around $12 billion by 1993, up from $8 billion last year.

What are your plans to facilitate full utilization of the self-care/self-medication field?

ANSWER:

I believe that societal trends indicate that the American consumer is insisting on taking greater responsibility for his or her own health. As a physician, I would encourage patients to be partners with their doctors in making decisions about their health care and to educate themselves as much as possible about prevention and treatment of health problems. Self-care/self-medication is becoming an increasingly significant component of our health care system, which can result in helping to contain health care costs. The Federal government must work with consumers, health professionals, and industry to shape the future course of self-care.

Senator Hatch

4. **Question:**

You have expressed special concern for the health care needs of minorities and the elderly. One-third of the dialysis and transplant patients served by Medicare's ESRD program are over age 65, and nearly 40 percent are minorities. Reimbursements for dialysis were cut in 1983 and again in 1986, and patient mortality rates have increased every year since 1983. Yet, OMB is proposing another reduction. In light of the population served, and increasing mortality, what is your position on the dialysis reimbursement rate?

Answer:

Although there has been an increase in mortality among newly treated patients since 1982, there is no evidence that it is related to quality of care. Rather, about half of the increase in mortality is attributable to dialysis services being extended to an ever more fragile group of elderly (many of whom have other complications and comorbidities).

A study of patients whose renal failure occurred prior to 1983 shows that their mortality rates have remained stable or improved since 1983.

I have been advised by staff of the Health Care Financing Administration that there is no evidence that there has been a decline in dialysis capacity. In fact, in 1987, the number of new facilities increased faster than the patient population.

I would, of course, review all aspects of this important program, including the payment rates.

Senator Hatch

5. **Question:**

Dialysis patient death rates have been increasing in the United States while they are going down everywhere else in the world. The Congress was sufficiently concerned about rising mortality and erosion of quality of care in the ESRD program to order a study, now being performed by the Institute of Medicine, of the relationship between reimbursement and quality of care. The study will be completed in 1990. Do you agree with the position expressed last year by Dr. Bowen and Dr. Roper, that completion of the IOM study should be a prerequisite for any further dialysis reimbursement changes?

Answer:

It is my understanding that former HHS officials did not commit to a specific timeframe for issuing ESRD payment changes.

I am sure we will want to review the several existing studies to determine whether data are sufficient before making a decision about rate adjustments. For example, there have been two studies on the increasing mortality rate of ESRD patients (an Urban Institute study and a Health Care Financing Administration intramural analysis) independent of the Institute of Medicine study mandated by the Omnibus Reconciliation Act of 1987. These studies indicate that the higher mortality rate is based primarily on the fact that significantly more older patients are starting dialysis than have in the past. The Urban Institute study concluded that the mortality rates did not reflect declining quality and were not directly related to the composite rate, as mortality rates did not rise more for those facilites which experienced higher than average rate reductions.

The Department's report, "Review of the Impact of the Reduction of the Composite Rate for Renal Dialysis on Access and Quality of Care", was sent to Congress on December 30, 1988.

Senator Hatch

6. **Question:**

The FY 1990 budget proposes a savings of about $45 million by reducing the dialysis payment rate about $4 per treatment, despite two previous rate cuts since 1983, no adjustments of any kind for inflation since 1973, and rising patient mortality every year since 1983. Do you support this budget request?

Answer:

Payment rates for dialysis were reduced in 1983 and 1986 as a result of national audits on the cost of dialysis services. These audits determined that dialysis costs are decreasing.

According to the Health Care Financing Administration (HCFA), more recent cost audits have been conducted and HCFA is reviewing the latest data available to determine if the current payment rates reflect the costs of efficiently furnished dialysis services and promote home dialysis, as required by law. At the same time, HCFA is also carefully examining the potential effects of any rate change to ensure that access to dialysis services for Medicare patients and high quality of care are maintained.

Senator Hatch

7. **Question:**

On January 1, the Health Care Financing Administration began paying for nurse anesthesia services under a fee schedule. Proposed regulations were issued later on January 26. The payments for Certified Registered Nurse Anesthetists (CRNAs) under the fee schedule are substantially below the cost of actual CRNA services, according to both HCFA and the American Association of Nurse Anesthetists. As Secretary of HHS, how would you propose to handle or assist in this matter?

Answer:

The new policy was published as a Notice of Proposed Rulemaking on January 26, 1989, and the Department is soliciting public comment on it during the ensuing 60-day period. At the end of that period, all suggestions will be carefully evaluated. I believe it would not be appropriate for me to speculate on the outcome of that process.

8. Senator Hatch

QUESTION

As you know, the nation is experiencing a national shortage of registered nurses.

At the end of 1988, Secretary Bowen accepted a final report from his National Commission on Nursing. The report outlined a wide range of recommendations to retain nurses and to recruit men and women into the profession of nursing education. Despite this, former President Reagan's 1990 Budget request includes no funding for nursing. Please share with us what your recommendations to President Bush would be regarding federal funding of nursing education.

ANSWER

The Nursing Commission's recommendations to address the nursing shortage are complex and have multiple dimensions. The Commission concluded that the shortage was primarily the result of increased demand for RNs, some of which was attributed to inappropriate utilization of nurses. The Commission also identified several other factors such as salary, wage compression, work environments, and lack of professional autonomy. Many of the recommendations addressing these issues are directed to the private sector.

As in the past, we are faced with a problem of competing priories and limited resources. The department will continue the efforts of the Commission, working with States, the health care industry, and other private sector organizations to enhance and increase their support for nurse training. I am committed to the Department's playing a constructive role in helping to meet nursing personnel needs.

9. Senator Hatch

QUESTION

In this time of budget driven health policy, what public policy recommendation would you make to President Bush and the Congress regarding direct reimbursement of cost-effective, non-physician providers -- especially nurse practitioners?

ANSWER

This is an area I certainly would like to explore. I don't have a specific recommendation at this time.

10.

QUESTION

In addition to FDA resources on the human drug side, I am also concerned about the adequacy of resources for the Center for Veterinary Medicine. As the author of the "Generic Animal Drug and Patent Term Restoration Act," I am very mindful of the additional resources CVM will need to process the abbreviated generic applications resulting from the new law and, at the same time, meet their responsibility to review new animal drug applications. Can I count on your help to see that CVM's needs are not overlooked?

ANSWER

Yes. The review of applications for generic animal drugs will be a new workload for FDA. I understand that the agency is currently working to develop guidelines to carry out this new law, so that procedures will be in place for the industry to follow. We are currently reviewing our estimates of the resource impact of this workload. I will see that the resource needs of this program are always thoughtfully considered.

Senator Hatch

11.

QUESTION

Dr. Sullivan, a major issue during the last session of Congress was the passage of the Anti-Drug Abuse Act of 1988. During the development of the bill in the House and Senate, different positions were taken with regards to the certification of laboratories. In the House, they proposed to apply the NIDA standards to all laboratories, while we in the Senate only proposed to open up the certification of laboratories to non-Federal organizations, like the College of American Pathologists.

Dr. Sullivan, do you feel that there is a federal role in certifying all private laboratories that are interested in employee drug testing in the private sector?

ANSWER

As you are aware, the Congress considered it critically important to ensure the accuracy and reliability of drug testing in federal employee programs (P.L. 100-71, Section 50). I share this objective. If a man or a woman's career depends on a laboratory result, stringent standards for performing these sophisticated diagnostic assays must be enforced. Furthermore, employee drug testing is being challenged in many courts throughout the nation. The future use of this valuable tool depends to a great extent on the ability to ensure the courts that the accuracy and reliability of testing and the quality of laboratory performance can be maintained at an extremely high level.

The present approach to testing Federal employees, which rests primarily on standards of excellence and numerous quality standards, enforced in part through certification, meets this challenge. Many in the private sector, as well as numerous State legislatures, have adopted the HHS standards or used them as a benchmark for drug testing programs.

I am not certain whether the Federal government should operate a national certification program. The elements of the present standards were tailored to the Federal civilian personnel systems and do not necessarily fit the diverse situations of all private employers, or all State and local governments. Together with other components of the Administration that play a key role in the issue of employee drug testing, I plan to study the issues surrounding drug testing standards. I believe careful analysis is necessary before we take a position on the appropriate role for the Federal government in this area.

Senator Hatch

12.
QUESTION:

Dr. Sullivan, as a follow-up to the issue of drug testing, there is technology available to screen urine on site with automated technology that decreases the risk of human error at a lower cost than some of the current high technology approaches. Do you feel that this approach should be acceptable for private testing of employees?

ANSWER:

The technology to which you refer involves only the preliminary assay required by our DHHS standards. This is a preliminary assay used only to separate negatives from those specimens which may be positive. Because of the inherent inaccuracies in all screening technology, the Mandatory Guidelines for Federal Workplace Drug Testing Programs require a more specific, more sensitive follow-up confirmation assay to be absolutely certain that there is a drug/metabolite in the specimen. I do not believe, under any circumstances, that a screening assay should be used to make employment decisions without a confirmation assay.

Secondly, most errors that occur in urine drug testing are due to human error such as chain-of-custody problems or sample mix-ups. Until or unless on-site assays can be demonstrated to eliminate such errors as effectively as assays performed in laboratories, using procedures which provide a confirmatory test and maintain the chain-of-custody, I would not agree that they are an acceptable general alternative. It is not sufficient to compare the costs of the tests alone. An important element of the cost of urine drug testing is the quality-controlled procedures under which the assay is conducted.

13. Senator Hatch

Question

There are about 37 million people that are uninsured in this nation. We will be considering one or more options to address this problem during this session of the Congress. Dr. Sullivan, have you given any thought to how we can solve the problem of the uninsured in this country?

Answer

Both the President and I fully share your concern regarding people without health insurance: in fact, within hours after my confirmation by the Senate on March 1, I chaired a one-hour overview briefing on the subject of financing health care for low-income Americans. This is an indication that I intend this subject to be one of the highest priorities in my Department during my term as Secretary.

However, it would be premature for me to point toward any specific solutions. I want to sound a cautionary note here and make three points:

- First, we need to be careful to focus our attention on high-priority people. For instance, approximately 8 million uninsured are in families with incomes above $30,000 per year, a group that is not the highest public policy priority. With funding so limited, we must make careful choices and find targeted, cost-conscious solutions.

- Second, there are multiple mechanisms for meeting the needs of the uninsured: some are insurance approaches like Medicaid and workplace health insurance; but others provide direct delivery of essentially free services - like public hospitals or community health centers. I am not prepared at this point to accept that we should scrap these direct care approaches in favor of an insurance model. This requires more study which we intend to carry out.

- And third, responsibility for solution of the problems of the uninsured must certainly be shared: the health services community; commercial insurers; employers; governments on all levels - state and local as well as Federal; and the uninsured themselves must all contribute to solving these problems.

14. Senator Hatch

QUESTION:

We all know how devasting the disease of AIDS is and how much heartache it causes, but there is one population that we hear too little about -- those young children born with AIDS or who get infected through infected blood products. Dr. Sullivan, I understand that usually there are about 400 patients needed to make up a clinical trial. In view of this do you think that FDA should modify its position to look at the effect of new HIV drugs for children?

ANSWER:

The Department and the Food and Drug Administration agree that we need to place the highest priority on the development of clinical data which will allow the appropriate labeling and use of drugs in children with AIDS. The extent of data needed to suppport such labeling and use is a complex problem. There is no fixed number of patients needed for clinical investigations that would provide an appropriate scientific basis for such clinical use. Rather, many variables need to be considered, including whether the use in children is an extension of comparable use in adults, a major new use of a product marketed for a non-AIDS use, or an original marketing application for a new product. The strength of the therapeutic effect being studied, the ability to identify clearly and quantify the clinical benefits being studied, the nature and course of the disease being studied, and the type of control data proposed for use in evaluating the product's effect are also major factors in determining study size.

In addition, we are absolutely committed to working with sponsors to design studies that will develop data on pediatric AIDS drugs as rapidly as possible. This includes making the studies as small as is feasible to achieve the study objectives. When the necessary factors are considered, the number of patients required for a trial can range from fewer than 25 to hundreds, or perhaps thousands. For example, a Phase I clinical trial, which is conducted to determine the safety and side effects of a new drug or treatment, typically involves 20-40 patients. A Phase II clinical trial, which compares the efficacy of the new drug or treatment against a standard or different experimental treatment, requires many more patients depending on the range of differences in efficacy expected between the two treatments. If a large difference in efficacy is anticipated, then fewer patients would be required to detect it. If minor differences in efficacy are anticipated, then a larger number of participants would be required to detect it. The numbers for this type of a trial can range from less than one hundred to thousands.

Senator Hatch (Qn 14)

A cumulative total of 1,396 children with AIDS has been reported as of 1/31/89, more than half of whom have died. Clinical trials in children with AIDS therefore must be very carefully designed and of high scientific priority because of the limited number of children who are available to participate. The number of patients needed for a clinical trial, however is not governed by the number of patients available.

The FDA is reviewing the pediatric investigation guidelines and the relevant regulations governing pediatric investigation and uses. Because this includes difficult scientific and ethical questions, the agency will involve the larger medical community, including the Academy of Pediatrics, in this review. In the meantime, the FDA review staff has worked successfully with NIH and other sponsors to avoid delays and resolve any concerns on initiation of studies in pediatric AIDS patients.

Response to Questions Submitted for the Record by
Senator Dan Coats

Question 1:

I would like to ask you a series of questions related to abortion activities in Title X projects.

(a) Do you believe for purposes of Title X that abortion is a method of family planning?

(b) Do you agree with the statement made by President Reagan on July 30, 1987 that "At present, the coexistence of abortion with federally-supported family planning services fosters the view that abortion is an acceptable and government-sanctioned method of family planning"?

(c) In your opinion, should Title X clinics which refuse to separate their abortion activities from legitimate forms of family planning be eligible to receive Title X funds?

(d) What steps will you take to implement proposed regulations creating a wall of separation between abortion and legitimate family planning? Will you direct the Department to appeal- if necessary to the Supreme Court - all court rulings which would overrule, in whole or in part, those regulations.

(e) What further steps will you take to assure that the original legislative intent of Congress with respect to Title X is carried out?

Answer:

(a) I agree with the view embodied in Title X that abortion is an unacceptable method of family planning and that, as such, Title X family planning should not include abortion-related services. I support the concept that proper family planning should reduce the incidence of abortion.

(b) Abortion is antithetical to the purposes of Federal family planning programs. It is important that the integrity of the Title X program be established as a program which in no way promotes or facilitates access to abortion. The message of the Title X regulations issued on February 2, 1988 is that the Federal government does not sanction abortion as a method of family planning and that it will not provide funding for actions that assist a woman with an unintended pregnancy to obtain an abortion.

(c) Clinics which refuse to separate their abortion activities from legitimate Title X family planning services should not be eligible to receive Title X funds. I support the rules issued on February 2, 1988 which require that a Title X project be organized so that it is physically and financially separate from prohibited abortion-related activities.

(d) I support the implementation of these important regulations and will ask the Justice Department to appeal any court order barring implementation. I will also ensure that the Department continues to implement the regulations, to the extent practical, where not enjoined.

(e) To the extent practical, I intend to implement the new rules where not enjoined by court order from doing so.

Question 2:

President Bush has said that the Federal Government must establish policies to encourage women with unplanned pregnancies to consider adoption as a life-giving, positive option for their babies. Pregnant adolescents especially need help in sorting through the long-term implications of their choices. Since the Title X family planning program is the largest Federal program specifically targeted at adolescents, this would be an important place to reach adolescents with information about adoption. Do you support allowing Title X projects to provide, at their discretion, adoption services?

Answer:

Title X projects are intended to provide services to help individuals determine the number and spacing of their children. This includes a broad range of acceptable and effective methods to limit or enhance fertility, including contraceptive methods and the management of infertility (adoption may be considered as one method of infertility management). Although Title X does not fund pregnancy care services after pregnancy has been diagnosed, Title X projects are required to facilitate access to prenatal care and social services, including adoption services, that might be needed by a pregnant client to promote her well-being and that of her child.

Question 3:

The Adolescent Family Life Demonstration Program is the only Federal program that targets adolescents with a message of abstinence and provides real alternatives to abortion (including the option of adoption). Can we count on your support for full funding of this demonstration program?

Answer:

I support continued full funding of the Adolescent Family Life Program. As you may know, President Bush's budget provides for full funding of the program at $10 million. As I stated before the Senate Finance Committee last week, I intend to actively encourage adoption and other alternatives to abortion.

Question 4:

Each year, over 1.5 million women undergo abortions. Since the legalization of abortion in 1973, 20 million abortions have been performed in the United States.

On January 9, the Surgeon General of the Public Health Service reported to the President his conclusions on the health effects (both physical and psychological) of abortion for women.

The Surgeon General found documentation that after abortion there can be infertility, a damaged cervix, miscarriage, premature birth, low birth weight babies, etc. But he further noted that conclusive data did not exist due to poorly kept records.

With regard to psychological damage, he concluded that "at this time, the available scientific evidence about the psychological sequelae of abortion simply cannot support either the preconceived beliefs of those pro-life or of those pro-choice." The Surgeon General then recommended to the President that consideration be given to going forward with an appropriate prospective study on women who have undergone abortions.

Given the apparent lack of information and data on the health risks associated with abortion will you direct the Centers for Disease Control to begin to conduct a prospective study on women who have undergone abortions?

Answer:

The Centers for Disease Control has looked into the feasibility of a study of the physiological and psychological consequences of childbearing.

At the request of the Surgeon General, CDC convened a meeting of invited consultants on February 29, 1988 to discuss the feasibility of conducting a prospective study.

Although the group members seemed to agree that a prospective study of abortion/childbirth morbidity would be valuable, they also agreed that there are significant problems designing and implementing such a study. The best study design would be methodologically difficult, including enrollment of large numbers of women prior to pregnancy, with frequent follow up until pregnancy, and then post-pregnancy follow up for at least 5 years. New psychological instruments would need to be developed and standardized. I will work with the Director of CDC to explore the practicality of undertaking such a study.

Question 5:

This past year, the Senate entertained floor debate on the issue of whether a spouse should have the right to know that his or her spouse has been infected with the AIDS virus. In light of the deadly nature of this disease, do you believe that a spouse should be notified?

Answer:

The Department of Health and Human Services has a stated policy to strongly encourage notification of sexual and needle-sharing partners of HIV positive persons as part of the nation's HIV prevention strategy.

This policy was published in CDC's Morbidity and Mortality Weekly Report in August 1987 and was expanded and emphasized in a special report on partner notification published in July 1988.

CDC has notified States that they must have a plan for partner notification as a condition of funding for AIDS prevention programs. As of July 1988, all 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands had a policy of urging HIV positive patients during their counseling sessions to notify their own sex and needle-sharing partners. In addition, 48 States plus the District of Columbia and the Territories provide health department assistance to infected persons in notifying at least some partners if requested.

One of the most important reasons that State and local health departments have not provided more widely available assistance in partner notification is that the necessary resources--both financial and trained personnel--are not available to them.

The Department will work to enhance the effectiveness of programs for notifying the spouse of a person who is infected with HIV. On an ethical basis, there is a compelling argument for such a policy.

The primary purpose of spouse or other partner notification programs is to reduce transmission of HIV in our population. The way in which such programs are structured has a major impact on their effectiveness.

The most desirable way to effect spousal notification is by supporting the infected person in the process of notifying his or her own spouse. Programs, such as those operated by blood banks to counsel seropositive donors, have demonstrated that with sufficient support, most married HIV infected persons are able to and will notify their own spouses. Some may require assistance.

Adoption of such a program at the Federal level still will require implementation and enforcement at the State and local

level. We have already demonstrated, however, that with proper support and encouragement, the States and local areas will implement such programs in the absence of Federal legislation, and will expand these programs as resources become available.

Many professional societies, including the American Medical Association and the American Academy of Pediatrics, are considering positions strongly encouraging spouse and sex partner notification. These positions should be encouraged, and the Department should work with these organizations as well as with State Medical Societies and other organizations to develop educational programs for physicians to help them deal with this important issue.

A major concern of all groups is that coercive spousal or partner notification programs not discourage individuals at high risk of HIV infection from participating in counseling and testing or drive them towards participation only in anonymous testing programs in which sex partner identification would not be possible.

Were Congress to pass legislation mandating notification of spouses of HIV infected persons, I would do my best to see that such requirements are complied with. It will be important to consider, in developing any such requirements, the issue of physician liability.

Question 6:

There are large discrepancies in the estimates about the actual number of persons who have been infected with the AIDS virus. Some federal health officials estimate the number to be up to 1.5 million. Others place the number closer to 10 million. In June of 1986, President Reagan ordered the Centers for Disease Control to conduct a wide-spread epidemiological study to determine the rate and prevalence of the virus. That study was never begun. Will you direct the CDC to conduct a wide-spread study?

Answer:

CDC estimates that the number of persons in the United States infected with HIV is between 1.0 and 1.5 million. This estimate is compatible with data obtained from CDC's "family of HIV seroprevalence surveys," testing of military recruits, results from HIV surveillance in sentinel hospitals, and serosurveys of childbearing women.

In response to President Reagan's directive, CDC has awarded a contract to conduct a national household survey to determine the prevalence of HIV in the general population of the United States. The contract requires the work to be completed in two phases. Phase I is a feasibility study, and Phase II is the national survey. Phase I is currently underway.

If the results of the feasibility study show that it is possible to obtain accurate information at acceptable cost from a household survey of HIV seroprevalence, CDC will recommend that the full national survey be conducted, and CDC will request the funds necessary to conduct that survey. If pilot and pretest results indicate that accurate data cannot be obtained from such a survey, CDC would not recommend proceeding. Accurate information is critical, but a survey which either underestimated or overestimated HIV seroprevalence could impede efforts to plan appropriately for AIDS/HIV control and prevention efforts and necessary services.

Question 7:

During the 100th Congress, there was an effort here in the Senate to enact a Federal confidentiality law. That law would have repealed State laws that allow certain individuals to be notified if they will handle or have handled body fluids of an AIDS patient. Do you support enactment of a Federal confidentiality law which does not take into account individuals who come into contact with the AIDS virus?

Answer:

I believe that strong confidentiality protections for information about AIDS patients or persons infected with HIV are necessary, and I also believe that any such protections must include provisions for revealing information, under carefully controlled and limited circumstances, when it is necessary to protect the health of others.

I understand that the Department is now studying, at the request of Congress, the State laws that protect the confidentiality of information about AIDS patients and persons with HIV-infection. When that study is completed, and we have a sense of the extent and nature of the protection under State law, I will consider whether Federal legislation is necessary or desirable, or whether this is best left to the States.

Question 8:

Do you believe that living embryos, fetuses, and newborns should be protected from biomedical and behavioral research activities that involve greater than minimal risk of suffering, injury, or death unless the activities are designed to benefit the fetus or newborn?

Answer:

The Department of Health and Human Services has a longstanding commitment to the protection of all human subjects in research. In addition to the Department's broad regulations protecting research subjects, there are special regulations to guard against exploitation of vulnerable research subjects--especially pregnant women, fetuses and children.

Our regulations prevent the use of <u>living fetuses</u> in research unless there is a therapeutic benefit to the fetus or unless the research poses essentially no risk to the fetus (the test for this latter exception is that the research is conducted on fetuses in utero without reference to whether the fetus is to be carried to term or not). Congress has codified these strong protections into section 489 of the Public Health Service Act.

Question 9:

Fetal tissue implants may offer the promise of improving the treatment of a number of intractable afflictions ranging from Parkinson's disease to diabetes. I say may because scientists are still debating the effectiveness of such procedures. While the goal is certainly admirable, the means used to achieve the goal, namely harvesting aborted children, raises numerable ethical and moral questions. Do you believe that an unborn or newborn child who has died as a result of an induced abortion should be used for purposes of research or transplantation?

Answer:

Generally, fetal, child, and adult cadavers are now treated largely alike under Federal and most State laws. However, we need to recognize that fetal cadavers, unlike adult and child cadavers, often become available as a result of a volitional act, namely, an induced abortion.

In March 1988, the Assistant Secretary for Health imposed a moratorium on NIH-funded research involving the transplantation of human fetal tissue from induced abortions. This moratorium was put in place in order to give the NIH the opportunity to examine the ethical, legal and scientific ramifications through an independent advisory committee.

I anticipate that it may be a month or so before I formally receive the complete package. At that time, I would expect to review the entire file and consult thoroughly with members of Congress and various participants of the ad hoc panel, among others.

I can assure you that guiding my decision is a strong conviction that no action should be taken that would encourage or promote abortion. It would not be appropriate to encourage women to have an induced abortion for the purpose of obtaining tissue for research.

Question 10:

Dr. Sullivan, I have been troubled by reports that the Child Abuse Amendments of 1984, which prohibit discriminatory denial of medical treatment to children born with disabilities, have been inadequately enforced. In particular, I am told that quite a number of the state agencies that get federal funds to enforce that law have policies that on their face are out of compliance with it. Would you commit the Department, under your leadership, to require the state agencies to submit their policies and procedures to HHS? And would you commit the Department to conduct a thorough review of those policies to ensure that any state agency that is found to be out of compliance revises its policies as a condition of receiving federal funding under this program?

Answer:

I plan to look into this matter and to explore with the Justice Department and HHS Department personnel what our authorities are with respect to the Child Abuse Amendments of 1984 and the extent to which we are meeting our responsibilities. If there are deficiencies, I will take steps to correct them.

Question 11:

I have one further question about the enforcement of this law. The law includes a very detailed standard for what medical treatment must be provided children born with disabilities. It is equally precise about the exceptions--what treatment may legally be withheld. But I am told that there are some who argue that states do not have to enforce this federally defined standard of care to get funding. They say that denials of treatment in violation of this standard of care must be reported to a state agency, but that the agency and the state courts don't actually have to require that treatment be provided in accordance with it--that each state can set its own rules on who will live and who will die. My question is whether it will be the intention of HHS under your leadership to enforce the congressionally defined standard of care, or whether you will fund states whose agencies or courts apply a different standard of care?

Answer:

Although I have not personally reviewed the child-abuse legislation and its implementing regulations, I understand they do contain detailed requirements States must follow in dealing with reports of withholding of medically indicated treatment to infants.

I further understand that an Office of Human Development Services task force is looking into (1) whether States have the necessary processes in place to comply with these requirements and (2) what further steps the Department should take to encourage and promote enhanced compliance in this area. After I am confirmed, I will ask HDS to update me on the task force's progress.

Question 12:

The absence of reliable data on the number of children in foster care makes it difficult to analyze and monitor the movement of children in and out of substitute care. Will you work with the Office of Management and Budget to put in place a system to enable us to gather foster care data?

Answer:

I understand that the Office of Human Development Services is already working with OMB to develop an extensive plan for collection of data covering children in foster care.

ADDITIONAL STATEMENTS

JOHN LEWIS
5th DISTRICT, GEORGIA

COMMITTEES
PUBLIC WORKS AND TRANSPORTATION
SUBCOMMITTEES
ECONOMIC DEVELOPMENT
PUBLIC BUILDINGS AND GROUNDS
WATER RESOURCES

INTERIOR AND INSULAR AFFAIRS
SUBCOMMITTEES
NATIONAL PARKS AND
PUBLIC LANDS
INSULAR AFFAIRS

WASHINGTON OFFICE
501 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-3801

DISTRICT OFFICE
THE EQUITABLE BUILDING
100 PEACHTREE STREET, N.W.
SUITE 810
ATLANTA, GEORGIA 30303
(404) 659-0116

Congress of the United States
House of Representatives
Washington, DC 20515

John Lewis

February 27, 1989

Chairman Kennedy, Members of the Labor and Human Resources Committee, I urge the Members of this distinguished panel to confirm President Bush's nomination of Dr. Louis Sullivan as Secretary of the U.S. Department of Health and Human Services.

Dr. Sullivan is a resident of my district, the Fifth Congressional District of Georgia. I have known and have had the pleasure of working with Dr. Sullivan on numerous health care initiatives for more than twelve years. He has led Morehouse Medical School in its mission to serve the underserved. And for that, all of us are grateful. His work at the Morehouse School of Medicine has helped to improve the quality of life in the City of Atlanta, in the State of Georgia, and in urban and rural communities throughout our nation.

During his medical career, Dr. Sullivan has distinguished himself as someone who makes things happen. He is a creative visionary who turns dreams into reality.

As a founder of the Morehouse School of Medicine, the founding President of the Association of Minority Health Professional Schools and the founding dean and director of the Medical Education Program at Morehouse College, he has made a significant contribution to improving the quality of care available to the poor and to ensuring the availability of quality health care to the poor.

Dr. Sullivan's resume is too long for me to review at this point. However, his resume reflects - and I can testify to - the fact that Dr. Sullivan is an able manager and administrator who is experienced at making tough and hard administrative decisions.

I am proud and pleased that President Bush had the confidence and foresight to nominate this American Medical pioneer to head the U.S. Department of Health and Human Services. Again, I urge the Committee's approval of Dr. Sullivan's nomination.

TESTIMONY SUPPORTING THE NOMINATION OF LOUIS W. SULLIVAN, M.D. AS SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

I am Stuart H. Shapiro, M.D., M.P.H., Vice President for Health Care Systems and National Medical Director of Nutri/System, Inc. Nutri/System provides comprehensive weight loss and weight control services through it's 1,100 centers throughout North America.

As Dr. Louis W. Sullivan well knows, America's health care system is primarily cure-oriented. We are spending, justifiably so, billions of dollars on treating heart disease, AIDS, strokes, cancer, diabetes, arthritis, respiratory problems, etc. We are spending billions of dollars, justifiably so, on research to find better cures for each of these diseases. Unfortunately, we are spending only a small fraction of the American health care dollar on primary and secondary prevention services.

Among the most serious preventable health problems, and fortunately a health problem that we also know how to treat, is obesity. Tragically there are 34 million adult Americans who are obese -- seriously overweight. There are another 34 million who are somewhat overweight. These 68 million adult Americans - more than one in three - all are at higher risk of increased morbidity and mortality. Obese Americans have higher incidence of heart disease, hypertension, strokes, diabetes, cancer, gall bladder disease, hypercholesterolemia, arthritis, and respiratory problems.

In fact, Kannel and Gordon stated in a U.S. Department of Health Education Welfare publication [NIH Publication #79-359] that "if everyone were at optimal weight, there would be 25% less coronary heart disease and 35% less congestive failure and brain infarction". Other studies have indicated that if all overweight Americans lost this excess weight and had ideal body mass indices there would be a "total reduction [in mortality] of 15% corresponding to 3 years of added life expectancy." Imagine, simply by losing weight, we as a population could extend our life by 3 years.

Last year Dr. C. Everett Koop, the Surgeon General of the United States, took a significant first step in outlining health problems relating to nutrition when he published the Surgeon General's Report on Nutrition and Health. I hope that this report will have the same significance in the year 2000 as the Surgeon General's Report on Smoking and Health did when it was published 25 years ago.

Dr. Louis Sullivan has had a long and prestigious career in research, health care delivery, and education. President George H. Bush made an ideal choice for Secretary of Health and Human Services. Dr. Sullivan knows that it is better to have an ounce of prevention than a pound of cure. I can therefore as Vice President for Nutri/System, Inc., and as Chairman of the Nutri/System National Health Sciences Advisory Board, strongly endorse the nomination of Dr. Sullivan and hope that the Senate Committee on Labor and Human Resources and the full Senate will act quickly and confirm him to this very important post.

We hope that Dr. Sullivan will then take the next step in implementing the urgently needed educational and service programs relating to nutrition and health. We suggest that he immediately convene a task force comprised of representatives from the public and private sectors to address the problems of both under-nutrition and obesity in America. This public/private partnership would join together to implement the recommendations of the Surgeon's General's Report on Nutrition and Health.

Thank you.

The CHAIRMAN. The committee stands in recess.
[Whereupon, at 11:36 a.m., the committee was adjourned.]

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